Revised 06/10/2015

Rhode Island Department of Health

Application and Instructions for:

Manager Certified In Food Safety Training Program

Name of Business

Previous Business Name & License Number (If Any)

OFFICE USE ONLY

	Initials	Date
Approved by F.O. Supervisor		
Profile Entered By		
License ID#		
Receipt No.		
License No.		

INSTRUCTIONS

Attach the following in specified order:

A. Sources and locations of potential students, faculty, classrooms, and other resources

B. Names and qualifications of instructors (Attach copies of "Instructor Applications")

C. Copy of cirriculum, including any provision for practical experience

D. Copy of the course syllabus, which shall include:

1. Text books and other teaching materials used

2. Methods and locations used for instructions

3. Course content

4. Topics and length of class meeting

5. Methods used to determine students participation and presence during the course sessions, examples, sign-up sheets, roster, provisions for make up work, etc.

Please complete the enclosed mandatory addendum form with your federal tax identification number (FEIN)

Submit completed application and documentation to:

Rhode Island Department of Health
Division of Food Protection
Food Manager Certification Program
Three Capitol Hill
Room 203
Providence, RI 02908-5097

If you have any questions concerning this application, call the Department of Health, Office of Food Protection at (401) 222-2749.

State of Rhode Island and Providence Plantations
Department of Health
Office of Food Protection

Facility Name: Please provide the name of the facility (as known to the public) for which you are applying for this license.	Name:
Approved Instructor: State regulations require all approved training programs to employ only certified food safety instructors. Please provide the name and license number of the certified instructor(s) with your program in the space provided.	Name: License # Name: License # Name: License #
Course Coordinator: Please provide the name and telephone number of a person we can contact concerning this program.	Name: Phone Number: ( )
Facility Mailing Information: Please provide the mailing information for all communication regarding this license. (**Not published on HEALTH website).**	Address Line 1 Address Line 2 Address Line 3 City,State, ZipCode Country (only if not in US) Phone: Fax: Email Address:
Facility Location Information: Please provide the location information for this facility. **(Published on HEALTH website)**	Address Line 1 Address Line 2 Address Line 3 City,State, ZipCode Country (only if not in US) Phone: Fax: Email Address:
SSN/FEIN: **(Social Security Number/Federal Employer Identification Number)** **Please note if you are a sole proprietor this number may be your SSN.**	Pursuant to Chapter 76 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator. **SSN/FEIN #:**

Affidavit of Applicant Read, sign, and date this affidavit.	**AFFIDAVIT AND SIGNATURE** **I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.** **I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.** **Signature of Authorized Person** — **Date of Signature (MM/DD/YY)** **Printed Name of Authorized Person** **Title of Authorized Person**

.