

RI Department of Health

Application and Instructions for Food Business:



Caterer or Commissary

Applicant Name (Name of Business)

Previous Business Name & License Number (If Any) at this address

OFFICE USE ONLY

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

INSTRUCTIONS

- Registration shall be based upon **Satisfactory Compliance** with all applicable laws and regulations.
- Registration forms must be either typed or legibly printed using a ball point pen, except signatures, which must be written in ink. Please answer all questions. Do not leave blanks. Incomplete applications will be returned to you and your license/permit will not be issued.
- Attach check/money order to the front of this application and mail to: Office of Food Protection, 3 Capitol Hill, Room 203, Providence, RI 02908-5097. Please do not hand deliver this form to the Department of Health. A receipt or cancelled check does not guarantee licensure.

Application Fees:

Caterer or Commissary \$280.00

- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash.
- If you have any questions concerning this application, call the Department of Health, Office of Food Protection at (401) 222-2749.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

Please complete section(s) below.

Note to Applicants submitting plans:

Plan Review

RIGL 23-1-31. Approval of construction by director. – A plan review fee for new establishments, and for establishments where the cost of renovation exceeds 50 percent (50%) of the value of the establishment, shall be charged. The plan review fee for these establishments shall equal the annual cost of the license/registration.

A plan review fee of \$_____ is included with this application.

I have enclosed a separate check/money order payable to "General Treasurer, State of Rhode Island".

Please check and indicate the type of operation by choosing **one** only.

- School K-12
- College/University
- Residential/Business
- Hospital
- Other (describe)_____



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: _____

Facility Contact Person:

Please provide the name and telephone number of a person we can contact concerning this facility.

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: _____

Ownership Type:

Please check ONE

- | | |
|--|--|
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Limited Liability Company |
| <input type="checkbox"/> Governmental Entity | <input type="checkbox"/> Sole Proprietorship |
| <input type="checkbox"/> Partnership | <input type="checkbox"/> Limited Partnership |
| <input type="checkbox"/> Partner | |

Ownership Information:

Please provide the ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.

LIST ONE ONLY - DO NOT SEND ATTACHMENTS

Name: _____

DBA (Doing Business As): _____

<p>Ownership Address Information:</p> <p>Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.</p>	<p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>City, State, Zipcode _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email Address: _____</p>
<p>Water Supply:</p>	<p>Does this establishment receive all or a portion of its water supply from an on-site well?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Sewage System:</p>	<p>Is this establishment serviced by a private sewage system (e.g. septic system)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Employees:</p> <p>Please indicate the number and types of employees.</p>	<p>Number of food handling employees: _____</p> <p>Number of non-food handling employees: _____</p>
<p>Certified Food Safety Managers:</p> <p>If you need additional space, please submit under separate cover.</p>	<p>Does this facility have a certified food safety manager? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please indicate name and license numbers below.</p> <p>Name: _____</p> <p>FMC #: _____</p>
<p>Affidavit of Applicant</p> <p>Read, sign, and date this affidavit.</p>	<p style="text-align: center;">AFFIDAVIT AND SIGNATURE</p> <p style="text-align: center;">This Application Must be Signed</p> <p>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.</p> <p>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.</p> <p>_____</p> <p>Signature of Authorized Person</p> <p>_____</p> <p>Printed Name of Authorized Person</p> <p>_____</p> <p>Title of Authorized Person</p> <p>_____</p> <p>Date of Signature (MM/DD/YY)</p>

State of Rhode Island and Providence Plantations



DEPARTMENT OF HEALTH

Office of the Director

Cannon Building

3 Capitol Hill

Providence, RI 02908-5097

Mandatory Addendum to License Application

Verification of Social Security Number/Federal Employer Identification Number and affidavit concerning taxpayer status

Pursuant to Chapter 75 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.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

Signature

Date

Social Security Number (SSN) or Federal Employer Identification Number (FEIN)

Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.

This form MUST be completed, signed and attached to your license application in order for us to process your application.