

Revised 06/09/2015

# Rhode Island Department of Health

## Application and Instructions for Food Business:



Market (Non-Profit)

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.		
Certified Food Safety Manager Required: 0 _____ 1 _____ > 1 _____		

# 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.
- You must attach 501(c)(3) with this application.
- Mail to: Office of Food Protection, 3 Capitol Hill, Room 203, Providence, RI 02908-5097.
- **Upon receipt of your completed application by the Department of Health, Office of Food Protection, please call (401) 222-2749 to schedule an operational inspection 2 weeks prior to opening. Note: You must have or employ an active Certified in Food Safety Manager registered with the Office of Food Protection (if applicable) prior to inspection.**
- 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 the 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.

- |  |  |
|--|--|
| <input type="checkbox"/> Bar, Lounge, Tavern                         | <input type="checkbox"/> Cafeteria, Buffet Service |
| <input type="checkbox"/> Fast Food Service                           | <input type="checkbox"/> Full Service Restaurant   |
| <input type="checkbox"/> Luncheonette, Snack Bar, Fountain           | <input type="checkbox"/> School (Satellite)        |
| <input type="checkbox"/> School (Commissary)                         | <input type="checkbox"/> School (In-Feed)          |
| <input type="checkbox"/> Scoop Ice Cream/Novelties(no manufacturing) | <input type="checkbox"/> Temporary Event           |
| <input type="checkbox"/> Take-Out Only                               | <input type="checkbox"/> Hospital                  |
| <input type="checkbox"/> Nursing Home                                | <input type="checkbox"/> Assisted Living Facility  |
| <input type="checkbox"/> Churches/Clubs/Bazaars                      | <input type="checkbox"/> Other (describe)          |



**State of Rhode Island**  
**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, Zip Code

Country (only if not in US)

Phone:

Fax:

Email Address:

<p><b>Facility Location Information:</b></p> <p>Please provide the location information for this facility.</p> <p><b>(Published on HEALTH website)</b></p>	<p>Address Line 1</p> <p>Address Line 2</p> <p>Address Line 3</p> <p>City, State, Zip Code</p> <p>Country (only if not in US)</p> <p>Phone:</p> <p>Fax:</p> <p>Email Address:</p>
<p><b>Ownership Type:</b></p> <p>Please check ONE</p>	<p><input type="checkbox"/> Corporation</p> <p><input type="checkbox"/> Governmental Entity</p> <p><input type="checkbox"/> Partnership</p> <p><input type="checkbox"/> Partner</p> <p><input type="checkbox"/> Limited Liability Company</p> <p><input type="checkbox"/> Sole Proprietorship</p> <p><input type="checkbox"/> Limited Partnership</p>
<p><b>Ownership Information:</b></p> <p>Please provide the ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.</p>	<p style="text-align: center;"><b>LIST ONE ONLY - DO NOT SEND ATTACHMENTS</b></p> <p>Name:</p> <p>DBA (Doing Business As):</p>
<p><b>Ownership Address Information:</b></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, Zip Code</p> <p>Phone:</p> <p>Fax:</p> <p>Email Address:</p>
<p><b>Water Supply:</b></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><b>Sewage System:</b></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><b>Employees:</b></p> <p><b>Please indicate the number and types of employees.</b></p>	<p>Number of food handling employees:</p> <p>Number of non-food handling employees:</p>

<p><b><u>Certified Food Safety Manager(s) is required if potentially hazardous foods are prepared.</u></b></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 number below of primary food safety manager:</p> <p>Name: _____</p> <p>FMC #: _____</p>
<p><b>Chain Information:</b></p>	<p>Is this facility part of a chain operation?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Menu:</p>	<p>Please attach a copy of a complete menu from your establishment.</p>
<p><b>SSN/FEIN:</b></p> <p><b>(Social Security Number/Federal Employer Identification Number)</b></p> <p>Please note if you are a sole proprietor this number may be your SSN.</p>	<p>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.</p> <p><b>SSN/FEIN #:</b></p>
<p><b>Affidavit of Applicant</b></p> <p>Read, sign, and date this affidavit.</p>	<p style="text-align: center;"><b>AFFIDAVIT AND SIGNATURE</b></p> <p><b>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.</b></p> <p><b>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.</b></p> <p>_____</p> <p><b>Signature of Authorized Person</b></p> <p style="text-align: right;">Date of Signature (MM/DD/YY)</p> <p>_____</p> <p><b>Printed Name of Authorized Person</b></p> <p>_____</p> <p><b>Title of Authorized Person</b></p>