

RI Department of Health

Application and Instructions for:



Manager Certified In Food Safety (State/Municipal)

Applicant Name

OFFICE USE ONLY

	Initials	Date
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 or hand-deliver to: Office of Food Protection, 3 Capitol Hill, Room 203, Providence, RI 02908-5097. A receipt or cancelled check does not guarantee licensure.

Application Fees:

Food Safety Manager \$50.00

- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash. This fee is non-refundable.
- If you have any questions concerning this application, call the Department of Health, Office of Food Protection at (401) 222-2749.

NOTE: If you are **not** a State or Municipal Employee, This is the **WRONG** application. Please contact the Office of Food Protection at the above number for the correct application.

NOTE: Please notify the Office of Food Protection in writing within ten (10) days of a change of name, employment or address.

REQUIRED ATTACHMENTS:

If you answer yes to any one of the two disciplinary questions:

1. Please provide a letter with an explanation.
2. Two letters of good moral character must be submitted.

Please enclose a copy of your birth certificate or proof of lawful entry to the country or a copy of your driver's license.

Please attach a copy of your Food Safety Certificate along with hours of training.

Please complete the enclosed mandatory addendum form with your social security number.

Please attach a recent identification photograph in the space provided below:

Attach
Photo
Here



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

Name:

This is the name that will be printed on your License and reported to those that inquire about your License.

Do not use nicknames, etc.

Name: _____ Maiden Name: _____

Social Security Number:

_____ - _____ - _____

Gender:

M F

Date and Place of Birth:

Date _____ / _____ / _____ Place _____
City State

Residence Information:

It is your responsibility to keep the Department apprised of all address and phone number changes.

(Not published on the HEALTH web site).

Address Line 1 _____
 Address Line 2 _____
 Address Line 3 _____
 City, State, ZipCode _____
 Country (only if not in US) _____
 Phone: _____
 Fax: _____
 Email Address: _____

Business/Employment Information:

Please provide the employment information related to this license. Include Name of Business/Employer (ie. Memorial Hospital)

(Published on the HEALTH web site).

Facility Name _____
 Facility License Number _____
 Address Line 1 _____
 Address Line 2 _____
 Address Line 3 _____
 City, State, ZipCode _____
 Country (only if not in US) _____
 Phone: _____
 Fax: _____
 Email Address: _____

Business/Employer License Number:

MANDATORY

Please provide the RI Department of Health License Number of the Business where you will be working.
 (FSV/MRK) _____

<p>Education Information:</p> <p>NOTE: You must enclose a copy of course completion certificate or RECIPROCITY APPLICANTS enclose equivalent educational credentials or certification credentials from participating agency.</p>	<p>Did you complete a fifteen (15) hour Division approved Food Safety Training Course?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>Did you pass the Food Protection Certification Monitored Examination?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes,</p> <p>Course Location _____ Instructor License # _____</p> <p>Name of Testing Company _____</p> <p>Date of Examination _____ Certificate No. _____</p>
<p>Disciplinary Actions</p> <p>Check either "Yes" or "No" for each question. NOTE: If you answer "YES" to any question, you are required to furnish completed details, including date, place, reason and disposition of the matter.</p>	
<p>Disciplinary Question A</p>	<p>Have you ever been convicted of a violation of, or pled Nolo Contendere to any Federal, State or local statute, regulation or ordinance, or entered into a plea bargain related to a felony, (including convictions for driving under the influence), or related to the manufacture, distribution, possession, prescribing, administering or dispensing of drugs presently defined as controlled substances under (Chapter 21-28) of the General Laws of Rhode Island?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Disciplinary Question B</p>	<p>Have you ever had a membership in a professional society revoked, suspended, or limited in any manner or have you voluntarily withdrawn while under investigation?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</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 my 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> <hr style="width: 50%; margin-left: 0;"/> <p>Signature of Applicant</p> <hr style="width: 50%; margin-left: auto; margin-right: 0;"/> <p style="text-align: right;">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)

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.