

RI Department of Health

Application and Instructions for:



Certified Food Safety Manager (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 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:

Food Safety Manager \$36.00

- 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.
- 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.

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.

REQUIRED ATTACHMENTS:

Please enclose a copy of your birth certificate or copy of your driver's license.

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: _____

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) _____

Preferred Mailing Address: Please check ONE (Published)	<input type="checkbox"/> Residence Address <input type="checkbox"/> Business/Employment Address
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Education Information:	Did you complete a fifteen (15) hour Division approved Food Safety Training Course? <input type="checkbox"/> Yes <input type="checkbox"/> No
NOTE: You must enclose a copy of course completion certificate or RECIPROCITY APPLICANTS enclose equivalent educational credentials or certification credentials from participating agency.	Did you pass the Food Protection Certification Monitored Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, Course Location _____ Instructor License # _____
	Name of Testing Company _____
	Date of Examination _____ Certificate No. _____

Disciplinary Actions

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.

Disciplinary Question A	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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Disciplinary Question B	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? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Affidavit of Applicant Read, sign and date this Affidavit.	<p>AFFIDAVIT AND SIGNATURE</p> <p>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>
	<p>_____</p> <p>Signature of Applicant</p>
	<p>_____</p> <p>Date of Signature (MM/DD/YY)</p>