*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.

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

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

| | |
|---|---|
| **Facility Name**:<br><br>Please provide the name of the facility (as known to the public) for which you are applying for this license. | Name: |
| **Facility Contact Person:**<br><br>Please provide the name and telephone number of a person we can contact concerning this facility. | Name:<br><br>Phone Number:<br>( ) |
| **Facility Mailing Information**:<br><br>Please provide the mailing information for all communication regarding this license.<br><br>(**Not published on HEALTH website).** | Address Line 1<br>Address Line 2<br>Address Line 3<br>City, State, Zip Code<br>Country (only if not in US)<br>Phone:<br>Fax:<br>Email Address: |

| | |
|---|---|
| **Facility Location Information:**<br><br>Please provide the location information for this facility.<br><br>(P**ublished on HEALTH website)** | Address Line 1<br>Address Line 2<br>Address Line 3<br>City, State, Zip Code<br>Country (only if not in US)<br>Phone:<br>Fax:<br>Email Address: |
| **Ownership Type**:<br><br>Please check ONE | ☐ Corporation ☐ Limited Liability Company<br>☐ Governmental Entity ☐ Sole Proprietorship<br>☐ Partnership ☐ Limited Partnership<br>☐ Partner |
| **Ownership Information:**<br><br>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**<br>Name:<br>DBA (Doing Business As): |
| **Ownership Address Information**:<br><br>Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity. | Address Line 1<br>Address Line 2<br>Address Line 3<br>City, State. Zip Code<br>Phone:<br>Fax:<br>Email Address: |
| **Water Supply:** | Does this establishment receive all or a portion of its water supply from an on-site well?<br>Yes No |
| **Sewage System:** | Is this establishment serviced by a private sewage system (e.g. septic system)?<br>Yes No |
| **Employees:**<br><br>**Please indicate the number and types of employees.** | Number of food handling employees:<br>Number of non-food handling employees: |

| | |
|---|---|
| **Certified Food Safety Manager(s) is required if potentially hazardous foods are prepared.**<br><br>If you need additional space, please submit under separate cover. | Does this facility have a certified food safety manager? ☐ Yes ☐ No<br><br>If yes, please indicate name and license number below of primary food safety manager:<br><br>Name: _____<br><br>FMC #: _____ |
| **Chain Information:** | Is this facility part of a chain operation?<br><br>☐ Yes ☐ No |
| Menu: | Please attach a copy of a complete menu from your establishment. |
| **SSN/FEIN:**<br><br>**(Social Security Number/Federal Employer Identification Number)**<br><br>**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.<br><br>**SSN/FEIN #:** |
| **Affidavit of Applicant**<br><br>Read, sign, and date this affidavit. | **AFFIDAVIT AND SIGNATURE**<br><br>**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.**<br><br>**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.**<br><br>_____<br>**Signature of Authorized Person**<br><br>**Date of Signature** **(MM/DD/YY)**<br><br>**Printed Name of Authorized Person**<br><br>**Title of Authorized Person** |