Revised 10/24/2024

Rhode Island Department of Health

Application and Instructions for:

Manager Certified In Food Safety

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 ballpoint 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: Center for 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, Center for Food Protection at (401) 222-2749.

NOTE: If you are a State or Municipal Employee, this is the **WRONG** application. Please contact the Center for Food Protection at the above number for the correct application.

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

REQUIRED ATTACHMENTS:

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

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

If you are enclosing a birth certificate, please attach a recent identification photograph in the space provided below:

Attach

Photo

Here

State of Rhode Island and Providence Plantations
Department of Health
Center for 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:	**Please select from the dropdown.**
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 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) _____

Education Information:	Did you complete an eight (8) hour Division approved Food Safety Training Course? ☐ Yes ☐ 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? ☐ Yes ☐ No If Yes, Course Location _____ Instructor License # _____ Name of Testing Company _____ Date of Examination _____ Certificate No. _____
Social Security Number (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. **SSN #:** _____
Affidavit of Applicant Read, sign and date this Affidavit.	**AFFIDAVIT AND SIGNATURE** **This Application Must be Signed** **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.** **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.** _____ **Signature of Applicant** **Date of Signature (MM/DD/YY)**