

RI Department of Health

Application and Instructions for:



Manager Certified In Food Safety Instructor

Applicant Name

OFFICE USE ONLY

	Initials	Date
Approved by		
Certificate 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 certificate will not be issued.
- If you have any questions concerning this application, call the Department of Health, Office of Food Protection at (401) 222-2749.
- 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: Please notify the Office of Food Protection in writing within ten (10) days of a change of name, employment or address.**

DOCUMENTATION REQUIREMENTS

- Certified copy of college transcripts
- Test score for the Certified Manager in Food Safety monitored examination. Have testing company mail the test score directly to the Office of Food Protection.
- Please complete the enclosed mandatory addendum form with your social security number.

OTHER REQUIREMENTS

An Instructor must earn fifteen (15) hours of training (professional development units-PDU's) every three years in order to maintain their certificate of approval. Proof of attendance (certificates), copies of program/conference agendas and the number of training hours must be submitted to the Office of Food Protection for approval. Evidence of completion of PDU's may be submitted on an ongoing basis during the 3-year certification period.

Submit completed application and documentation to:

Rhode Island Department of Health
Office of Food Protection
Food Manager Certification Program
Three Capitol Hill
Room 203
Providence, RI 02908-5097

Institution/Company Sponsoring your course: Note: Only complete this section if affiliated with an institution ie. a university, hospital, school or food service company.. (Published on the HEALTH web site)	Name: _____ Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ City,State, ZipCode _____ Country (only if not in US) _____ Phone: _____ Fax: _____ Email Address: _____ Contact Person: _____
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Education Information:	Please list the highest degree earned _____ (Include a certified copy of transcript(s), please highlight courses pertinent to this application)
	(Enclose a copy of course completion certificate or enclose equivalent educational credentials)
	Did you pass the Food Protection Certification Monitored Examination? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Please List Name of Testing Company _____ Date of Examination _____ Score Received _____ (Please have the testing company send your test score directly to the Office of Food Protection)

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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Training Program: State regulations require all certified food safety instructors to be affiliated with an approved training program in the space provided.	Name of training program: _____ Or Name of consultant: _____
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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 Certificate of Approval 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)**



Rhode Island Department of Health

3 Capitol Hill, Providence RI, 02908-5097

MANDATORY ADDENDUM TO LICENSE APPLICATION

Tax Payer Status Affidavit / Identity Verification

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

Licensee Declaration

- I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.
- I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the Tax Administrator.
- I am currently pursuing administrative review of taxes owed to the state.
- I am in federal bankruptcy. (Case # _____)
- I am in state receivership. (Case # _____)
- I have been discharged from Bankruptcy.
(Case # _____)

Type of Professional/Business License for which you are applying

Full Name (Please Print or Type)

Social Security Number

Signature

Phone Number (including area code if not 401)

Date

Name of Business (If Applicable)

This form must be completed, signed and attached to your license application for processing.

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.