

# Rhode Island Department of Health

## Application and Instructions for Dairy Business Permit:



Milk Hauler

Name of Business

Previous Business Name & License Number (If Any) at this address

### 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.
- Mail to: Office of Food Protection, 3 Capitol Hill, Room 203, Providence, RI 02908-5097.
- If you have any questions concerning this application, call the Department of Health, Office of Food Protection at (401) 222-2749.
- **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.**
- 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 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”.



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

<p><b>Facility Name:</b></p> <p>Please provide the name of the facility (as known to the public) for which you are applying for this license.</p>	<p>Name:</p>								
<p><b>Facility Contact Person:</b></p> <p>Please provide the name and telephone number of a person we can contact concerning this facility.</p>	<p>Name:</p> <p>Phone Number:</p> <p>(            )</p>								
<p><b>Facility Mailing Information:</b></p> <p>Please provide the mailing information for all communication regarding this license.</p> <p><b>(Not published on HEALTH website).</b></p>	<p>Address Line 1</p> <p>Address Line 2</p> <p>Address Line 3</p> <p>City,State, ZipCode</p> <p>Country (only if not in US)</p> <p>Phone:</p> <p>Fax:</p> <p>Email Address:</p>								
<p><b>Facility Location Information:</b></p> <p>Please provide the location information for this facility.</p> <p><b>(Published on HEALTH website)</b></p>	<p>Address Line 1</p> <p>Address Line 2</p> <p>Address Line 3</p> <p>City,State, ZipCode</p> <p>Country (only if not in US)</p> <p>Phone:</p> <p>Fax:</p> <p>Email Address:</p>								
<p><b>Ownership Type:</b></p> <p>Please check ONE</p>	<table border="0"> <tr> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Limited Liability Company</td> </tr> <tr> <td><input type="checkbox"/> Governmental Entity</td> <td><input type="checkbox"/> Sole Proprietorship</td> </tr> <tr> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> Limited Partnership</td> </tr> <tr> <td><input type="checkbox"/> Partner</td> <td></td> </tr> </table>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Governmental Entity	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Partnership	<input type="checkbox"/> Limited Partnership	<input type="checkbox"/> Partner	
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<input type="checkbox"/> Partnership	<input type="checkbox"/> Limited Partnership								
<input type="checkbox"/> Partner									

<p><b>Ownership Information:</b></p> <p>Please provide the ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.</p>	<p><b>LIST ONE ONLY - DO NOT SEND ATTACHMENTS</b></p> <p>Name:</p> <p>DBA (Doing Business As):</p>
<p><b>Ownership Address Information:</b></p> <p>Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.</p>	<p>Address Line 1</p> <p>Address Line 2</p> <p>Address Line 3</p> <p>City, State, Zipcode</p> <p>Phone:</p> <p>Fax:</p> <p>Email Address:</p>
<p><b>Registration Information:</b></p> <p>(Milk Haulers licenses only)</p>	<p>If you haul/ship/transport milk via a milk tank truck, please indicate vehicle registration information below.</p> <p>Registration State _____ Registration Plate _____</p>
<p><b>SSN/FEIN:</b></p> <p><b>(Social Security Number/Federal Employer Identification Number)</b></p> <p>Please note if you are a sole proprietor this number may be your SSN.</p>	<p>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.</p> <p style="text-align: center;"><b>SSN/FEIN #:</b> _____</p>

**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 this 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.

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**Signature of Authorized Person**

**Date of Signature  
(MM/DD/YY)**

**Printed Name of Authorized Person**

**Title of Authorized Person**