

Revised 06/08/2015

# Rhode Island Department of Health

## Application and Instructions for Food Business:



Retail Food Peddler

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.		

# 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. A receipt or cancelled check does not guarantee licensure.
- **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.**

**Initial registration fee is prorated based on the date of application registration (check ONE below), automatic renewal payment due on following September 30 cycle at 100%.**

Licensing Cycle Expiration Date 9/30	August 1-December 31 (100%)	January 1-March 31 (75%)	April 1-July 31 (50%)
Retail Food Peddler	\$100.00 <input type="checkbox"/>	\$75.00 <input type="checkbox"/>	\$50.00 <input type="checkbox"/>

- 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.

**Please complete section(s) below.**

**Note to Applicants submitting plans:**

**Plan Review**

**One time plan review fee is not prorated**

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.  
 Plan review fee.....\$100.00  
 I have enclosed a separate check/money order payable to "General Treasurer, State of Rhode Island".

State of Rhode Island  
 Department of Health  
 Office of Food Protection

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



**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**