



**REGULATORY LICENSING UNIT  
 CERTIFIED FOOD MANAGERS PROGRAM  
 INITIAL / RENEWAL CERTIFICATION LICENSE APPLICATION  
 (Health and Safety Code (HSC), Chapter 438)**

Return both the completed application and **non-refundable fee** made payable to:  
 Cash Receipts Branch, MC 2003, Texas Department of State Health Services  
 P O Box 149347, Austin, Texas 78714-9347.

You may visit our website at: <http://www.dshs.state.tx.us/fdlicense/apps.shtm>  
**ALLOW 4-6 WEEKS PROCESSING TIME**

Budget: ZZ106
Fund: 126
LICENSE #:

Please note that this application is for a CERTIFICATION PROGRAM. A separate application package is required for a Recertification Program or a Test Site. Contact this office at (512) 834-6727 if you have any questions.

Name of Business Applying to Operate Program: \_\_\_\_\_

Name of Business Owner (Licensee of Program): \_\_\_\_\_

Physical Address of Program: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Mailing Address (if different from Physical Address): \_\_\_\_\_

Sponsor Name: \_\_\_\_\_

Telephone # at Physical Address: \_\_\_\_\_ Program's Fax #: \_\_\_\_\_

Program's Email Address: \_\_\_\_\_

Program's Website (URL): \_\_\_\_\_

**INITIAL / RENEWAL LICENSE**

Licensing Fee - \$600.00

Late Fee - \$100.00

Late fees are assessed to any licensee who files for renewal after the license expiration date, or any returned check received after the expiration date.

VERIFICATION: I SWEAR OR AFFIRM THAT ALL INFORMATION IN THIS APPLICATION IS TRUE AND CORRECT. I FURTHER CERTIFY BY SIGNATURE HEREON, THAT I AM AUTHORIZED TO EXECUTE THIS DOCUMENT ON BEHALF OF THE CORPORATION AND I AM NOT CURRENTLY DELINQUENT IN THE PAYMENT OF ANY CORPORATION FRANCHISE TAXES OWED THE STATE OF TEXAS UNDER CHAPTER 171, TAX CODE. IF SIGNING THIS AS OWNER OF A SOLE PROPRIETORSHIP, I AM NOT DELINQUENT IN THE PAYMENT OF ANY CHILD SUPPORT OWED UNDER CHAPTER 232, FAMILY CODE. IF SIGNING AS A SOLE PROPRIETOR, I CERTIFY I HAVE FILED THE ASSUMED NAME CERTIFICATE IN APPROPRIATE COUNTIES PURSUANT TO BUSINESS AND COMMERCE CODE, CHAPTER 36. I FURTHER CERTIFY THAT I HAVE READ AND UNDERSTOOD CHAPTER 438 OF THE HEALTH & SAFETY CODE, THE APPLICABLE PROVISIONS OF 25 TAC, CHAPTER 229, AND AGREE TO ABIDE BY THEM.

\_\_\_\_\_  
 Signature of Program Licensee

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name & Title

**PURPOSE OF THIS APPLICATION:** Check Appropriate Box

**Initial Application**

**Renewal:** Renewals are valid for two years from the anniversary date. Failure to submit the renewal fee before the expiration date will result in a delinquency fee for each location and must be remitted before the license or permit will be issued.

**Amended:\*** Effective Date: \_\_\_\_\_

Change of Location  Change of Name  Other: \_\_\_\_\_

**Change of Ownership:\*** Effective Date: \_\_\_\_\_

Previous Business Name and License #: \_\_\_\_\_

**Out of Business:** Effective Date: \_\_\_\_\_ (I choose not to renew my Certification License)

\*A completed application must be submitted with appropriate fees prior to a change of license ownership, site location, or change of name. The effective date of change becomes the new anniversary date.

**PROGRAM INFORMATION:** Check All That Apply

**Program:**  Public Program  Private Program

**Language:**  English  Spanish  Other (please specify): \_\_\_\_\_

**Method:**  Classroom  CD  Other (please specify): \_\_\_\_\_

**Schedule:** A schedule of training may be requested for program audit purposes.

**EXAMINATION:** Only Department Approved Examinations may be utilized.

National (please specify): \_\_\_\_\_

**INSTRUCTORS:** List the name of each New & Renewal Instructor(s) who will teach for the program. Attach a completed Instructor or Instructor Renewal Application for each instructor listed below.

<u>Instructor Name *</u>	<u>New</u>	<u>Renew</u>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

- Please submit a list of any additional instructor names along with their Instructor Application.

**The following documents MUST be submitted with this application and licensing fee:**

**Initial Application:**  Instructor Application(s)  Program Curriculum (14 hr)

**Renewal Application:**  Instructor Application(s) new & renewals

Instructor and Instructor Renewal Applications may be downloaded from the CFM website at:

[www.dshs.state.tx.us/foodestablishments/cfm.shtm](http://www.dshs.state.tx.us/foodestablishments/cfm.shtm)

**ALLOW 4-6 WEEKS PROCESSING TIME**

**FAILURE TO PROVIDE ALL REQUIRED INFORMATION WILL DELAY ACCREDITATION**

**LICENSE HOLDER INFORMATION :** Complete the required ownership information.

Legal name of company must be identical to the name on your State Tax Payer's Identification on file with the Texas Comptroller of Public Accounts.

Legal Name \_\_\_\_\_ Tax Payer ID # or Charter # \_\_\_\_\_ Outlet # \_\_\_\_\_

Mailing Address of Licensed Establishment \_\_\_\_\_ City and State \_\_\_\_\_ Zip \_\_\_\_\_

**SOLE OWNER / PROPRIETORSHIP**

\_\_\_\_\_  
Name

**PARTNERSHIP**       **LP**       **LLP**       **LTD**

\_\_\_\_\_  
Name of Partnership \_\_\_\_\_ Effective Date of \_\_\_\_\_

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name

**UNIVERSITY / COLLEGE**       **COUNTY / DEPARTMENT**

\_\_\_\_\_  
Name

**CORPORATION**       **LLC**

\_\_\_\_\_  
Name of Corporation \_\_\_\_\_ Date and Place of Incorporation \_\_\_\_\_

\_\_\_\_\_  
President's Name

\_\_\_\_\_  
Officer's Name

\_\_\_\_\_  
Officer's Name

\_\_\_\_\_  
Name of Registered Agent

**CERTIFIED FOOD MANAGER PROGRAM  
INSTRUCTOR APPLICATION –NEW / RENEWAL**

The Certified Food Manager (CFM) **PROGRAM LICENSEE** must Mail or Fax the completed Instructor Application and ALL required documentation to: Food and Drug Licensing Group, MC 2003, Texas Department of State Health Services, PO Box 149347, Austin, TX 78756-3182. Telephone: (512) 834-6727, Fax: (512) 834-6741. Visit our website at: [www.dshs.state.tx.us/foodestablishments/cfm.shtm](http://www.dshs.state.tx.us/foodestablishments/cfm.shtm)

**FAILURE TO PROVIDE ALL REQUIRED DOCUMENTATION WILL DELAY PROCESSING**

<b><u>PLEASE TYPE OR PRINT LEGIBLY</u></b>	Program License Number: _____
1. Licensed CFM Program: _____	
2. Instructor Name (Candidate): _____	
Last	First
Area Code	Number
3. Telephone (Daytime): _____	
4. Email: _____	

**(NEW) Complete for a "NEW" license only**

5. Instructor Training Requirements - Certified Food Manager Certificate:  
 Attach a copy of current CFM Certificate
6. Instructor Experience or Education Requirement: Complete A or B  
 A. Graduate/Bachelor/Associate Degree Applicant:  
 Attach copy of transcript and diploma. The degree must be in area of Food Safety/Environmental Health/or Natural Sciences. OR  
 B. Work Experience Applicant: (Attach copy of work experience)  
 (1) 2 years of State or Local Health Department Regulatory Food Inspection Work Experience OR  
 (2) 5 years of Managerial Food Establishment Work Experience §229.172 ( g )(1 )

**(RENEWAL) Complete for a "RENEWAL" license only**  
 (Verification of training hours must be submitted with application)

7. Instructor Continuing Education (5 clock hours) : List all professional training methods required for certification.

Course Title:	Hours:	Date:
_____	_____	_____
_____	_____	_____

**AFFIDAVIT:** I hereby certify that the information given above is true and correct to the best of my knowledge. I understand at the time of audit, verification of documentation shall be provided at the request of the department. I further certify that I have read and understand applicable provisions of 25 Texas Administrative Code, Chapter 229.172 and agree to abide by them.

Signature of Instructor (Candidate): \_\_\_\_\_ Date \_\_\_\_\_ Signature of CFM Program Licensee: \_\_\_\_\_ Date: \_\_\_\_\_

<p><b><u>New:</u></b></p> <input type="checkbox"/> CFM <input type="checkbox"/> Work Experience <input type="checkbox"/> Transcript <input type="checkbox"/> Degree <input type="checkbox"/> Industry (5 Yrs) <input type="checkbox"/> Diploma <input type="checkbox"/> Regulatory (2 Yrs)	<p><b><u>FOR CFM OFFICE USE ONLY</u></b></p> <input type="checkbox"/> Approved <input type="checkbox"/> Instructors #: <input type="checkbox"/> Exp Date: <input type="checkbox"/> Disapprove:  <input type="checkbox"/> Disapprove: Comments:	<p><b><u>Renewal:</u></b></p> <input type="checkbox"/> Continuing Education (5)
		<p><b>Initials:</b></p> <p><b>Date:</b></p>