



**TEXAS**  
Health and Human  
Services

Texas Department of State  
Health Services

**BUSINESS FILING AND VERIFICATION  
SECTION  
CERTIFIED FOOD MANAGERS PROGRAM  
MINOR AMENDMENT CERTIFICATION  
LICENSE APPLICATION**

(Health and Safety Code (HSC), Chapter 438)  
Return both the completed application and **non-  
refundable check or money order** made  
payable to: Texas Department of State Health  
Services, RUL, Food & Drug Licensing, MC 2003  
P O Box 149347, Austin, Texas 78714-9347.

**CFM CERT  
PROG  
2101**

Budget:  
**ZZ106**  
Fund:  
**126**

LICENSE #:

Please note that this application is for a Certification Program. A separate application package is required for a Test Site. Applications may be downloaded at <http://dshs.texas.gov/food-managers/default.aspx>, or contact this office at (512) 834-6727.

Business applying to operate Program: \_\_\_\_\_

Name of owner (licensee of Program): \_\_\_\_\_

Physical address of Program: \_\_\_\_\_

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

Mailing address: \_\_\_\_\_

Telephone number at physical address: \_\_\_\_\_

Program's Email address: \_\_\_\_\_

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

**MINOR AMENDMENT**

**Licensing fee \$300.00**

**MILITARY PERSONNEL:**

Please check this box for a request to expedite this application. Request for expediting an application will be reviewed on a case by case basis **ONLY IF** instructor(s) completing page 4 is Military, retired Military, spouse of Military, or spouse of retired Military.

**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 am eligible to receive a license. 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 understand Chapter 438 of the Health & Safety Code, the applicable provisions of 25 Texas Administrative Code, Chapter 229, and agree to abide by them.

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

\_\_\_\_\_  
Printed name & title

\_\_\_\_\_  
Date

**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.

**Change of Ownership:**

Previous owner: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Amended: Effective date:** \_\_\_\_\_

Change of Location (previous location): \_\_\_\_\_

Change of dba name (previous name): \_\_\_\_\_

Other: \_\_\_\_\_

**Notice that firm is out of business** Effective date: \_\_\_\_\_

A completed application must be submitted with appropriate fees prior to a change of license ownership, site location, or change of DBA name.

**PROGRAM INFORMATION:** Check all that apply

**Program:**  Public Program  Private Program  
**Language:**  English  Spanish  Other (specify) \_\_\_\_\_  
**Method:**  Classroom  CD  Other (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.

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

Please submit a list of additional instructor names along with their Instructor application.

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

**Initial application:**  Instructor application(s)  Program Curriculum (14 hr)  
**Renewal application:**  Instructor application(s), new & renewals  
**Military Personnel:**  Confirmation of service &  
 Documentation of comparable training applicable to Instructor

**Application(s) new & renewals – see pages 1-2.**

Instructor and Instructor Renewal applications may be downloaded from the CFM website at: [www.dshs.state.gov/food-managers/default.aspx](http://www.dshs.state.gov/food-managers/default.aspx)

Allow 4-6 Weeks Processing Time.

**Failure To Provide ALL Required Information Will Delay Accreditation**

**License Holder Information.** Please list the 11 digit State Taxpayers Number on file with the Texas Comptroller of Public Accounts and the 9 digit Federal Employee Identification Number (EIN).

\_\_\_\_\_  
Taxpayer number

\_\_\_\_\_  
EIN number

For the information below, complete the **box** that applies to the ownership of the license.

**Sole Owner / Proprietorship**

\_\_\_\_\_  
Name

**Partnership**    **LP**    **LLP**    **LTD**

\_\_\_\_\_  
Name of Partnership

\_\_\_\_\_  
Effective Date

\_\_\_\_\_  
Partner name

\_\_\_\_\_  
Partner 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



Texas Department of State  
Health Services

## **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: <http://www.dshs.texas.gov/food-managers/default.aspx>

**PLEASE TYPE OR PRINT LEGIBLY**      Program License # \_\_\_\_\_

Licensed CFM program name \_\_\_\_\_

Instructor name (Candidate): \_\_\_\_\_

Telephone number: \_\_\_\_\_

Email: \_\_\_\_\_

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

Instructor Training Requirements – Certified Food Manager Certificate

Attach a copy of the current CFM Certificate

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

**OR**

2. 5 years of managerial food establishment work experience 229.172(g)(1)

3. Any Military service experience that is equal to or exceeds items 1 & 2 under B.

REV 4/10/17

**RENEWAL**

**Complete for a "RENEWAL" license only**

(verification of training hours must be submitted with application)

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

Course Title

Hours

Date

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**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

**FOR CFM OFFICE USE ONLY**

**NEW:**

- work experience  transcript  degree  industry (5 years)  diploma
- regulatory (2 years)  Military service confirmation  Military food service documentation

**RENEWAL:**

- Continuing Education (5)

**Status:**

- Approved
- Instructor number: \_\_\_\_\_  Exp Date: \_\_\_\_\_

- Disapprove

Comments: \_\_\_\_\_

**Initials:** \_\_\_\_\_ **Date:** \_\_\_\_\_