

APPLICATION FOR CERTIFIED FOOD MANAGER
1 West Wilson Street, Room 133
P. O. Box 2659
MADISON WI 53701-2659

Please Type or Print Following Information

Last Name	First Name	Middle Initial
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Social Security Number	or:	Driver's License Number
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Permanent Address:

Street			
City	State	Zip Code	County

Daytime Phone Number ()

Signature of Applicant	Date
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PLEASE ENCLOSE A PHOTOCOPY OF A CERTIFICATE, FORM OR LETTER, VERIFYING A PASSING SCORE FROM THE TESTING AGENCY. ORIGINALS SENT IN WILL NOT BE RETURNED.

Remit check for \$10.00 payable to: **Department of Health and Family Services**
Division of Public Health
Bureau of Environmental Health
P. O. Box 2659
Madison, Wisconsin 53701-2659

For Office Use Only:

ID#	Test Taken	Date Taken
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