

**RECERTIFICATION APPLICATION
FOR FOOD MANAGER**

1 West Wilson Street, Room 133
P. O. Box 2659
MADISON WI 53701-2659

Please Type or Print Following Information (Provide all requested information)

Last Name	First Name	Middle Initial
-----------	------------	----------------

Wisconsin Food Manager Certification ID #:	Expiration Date:
--	------------------

Social Security Number	or:	Driver's License Number
------------------------	-----	-------------------------

Permanent Address:

Street			
City	State	Zip Code	County

Daytime Phone Number ()

Signature of Applicant	Date
------------------------	------

PLEASE ENCLOSE A PHOTOCOPY OF A CERTIFICATE OR FORM, FROM THE COURSE SPONSOR VERIFYING THAT YOU HAVE COMPLETED AN APPROVED RECERTIFICATION COURSE. 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
-----	------------	------------