



**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR PUBLIC HEALTH**

**HOME-BASED PROCESSOR REGISTRATION FORM**

*Office Use Only*

CERTIFICATION FEE: <b>\$50.00</b>	EST. TYPE: <u>40</u>	EST. NO.: _____
DATE PAID: _____		COUNTY: _____
<input type="checkbox"/> CHECK <input type="checkbox"/> CASH <input type="checkbox"/> MONEY ORDER		REGION: _____
CHECK/M.O #:		

**PLEASE RETURN THIS FORM AND  
ACCOMPANYING PAYMENT TO:  
KY FOOD SAFETY BRANCH  
275 EAST MAIN STREET, HS1C-F  
FRANKFORT, KY 40621**

*Applicant please complete items 1- 5*

<b>1. APPLICANT INFORMATION</b>	<b>MAILING ADDRESS:</b>
APPLICANT/OWNER NAME: _____	Street: _____
PRIMARY NUMBER: _____ cell <input type="checkbox"/> home <input type="checkbox"/>	City: _____
SECONDARY NUMBER: _____ cell <input type="checkbox"/> home <input type="checkbox"/>	State: _____ Zip: _____
EMAIL ADDRESS: _____	

<b>2. PRIMARY RESIDENCE WHERE PRODUCTS ARE PROCESSED:</b>
Street: _____
City: _____ State: _____ Zip: _____
GPS coordinates, if known: Lat: _____ Long: _____

<b>3. LIST ALL HOME-BASED FOOD PRODUCTS TO BE PRODUCED:</b>
_____
_____
_____
_____

<b>4. INCLUDE THE FOLLOWING WITH THIS FORM:</b>
___ <b>\$50.00 registration fee</b> made payable to the KY State Treasurer

**NOTE: FORMS WHICH LACK THE ABOVE INFORMATION/ MATERIALS WILL RESULT IN REGISTRATION DELAY.**

<b>5. I attest that the information provided in this application is true and accurate and all homebased processing will be in compliance with KRS 217.015(56), KRS 217.136-137, and 902 KAR 45:090.</b>
Applicant Name (Please Print): _____
Applicant Signature: _____ Date: _____

\_\_\_\_\_ Health Authority (print)                      \_\_\_\_\_ SANITARIAN #                      \_\_\_\_\_ Health Authority (sign)                      \_\_\_\_\_ Date