

OCAL CERTIFIER REGISTRATION APPLICATION
INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED

See Page 2 for Instructions

OCal Certifier Registration Number (if not New): _____	NOP Certificate Number: _____
--	-------------------------------

☐ **NEW APPLICANT** ☐ **RENEWAL APPLICANT** ☐ **OWNERSHIP CHANGE**
☐ **RELOCATION**—Previous Address: _____

1. Firm Name			6. Mailing Address (if different or P.O. Box number)		
2. DBA (list additional DBAs on separate sheet if necessary)			7. Mailing Address (continued)		
3. Facility Address (number, street)			8. City	State	ZIP Code
4. Facility Address (continued)			9. E-mail Address		
5. City	State	ZIP Code	10. Website (URL)		

11. Does the applicant hold a valid National Organic Program (NOP) certificate and is the applicant accredited to the scope of handling/manufacturing?

☐ Yes (attach copy of NOP issued certificate) ☐ No (if no, application will be rejected)

12. Type of Ownership

☐ Individual/Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Nonprofit
☐ Other

13. Owner's Name / Corporate Name (if applicable)	State of Incorporation
---	------------------------

14. Owners' or Officers' Names and Titles	Owners' or Officers' Names and Titles

15. Registration Fee Due: \$ <u>100.00</u> Penalty on Registration Fee: (1.5% per month if over 30 days) \$ _____ Total Payment Due: \$ _____	California Code of Regulations Section 22085: If any information on this application is not provided, the application will not be processed . The applicant will have 30 calendar days from the date of notification from the department to submit all required information and fees or the application will be deemed abandoned .
---	--

Under penalties of perjury, I, The Owner, declare that the information included with this application and all attachments are true, correct, and complete. I, The Owner, also give permission for the fellow authorized representatives and/or signatories to speak about the application with CDPH.

16. Owner's Signature	Owner's Printed Name	Title: Owner/	Date
-----------------------	----------------------	---------------	------

Authorized representatives and/or signatories:

17. Business Operator (name/title)	Business Phone	24-Hour Emergency Phone	Business Operator E-mail
18. Correspondent (name/title)	Correspondent Phone	Alternate Phone	Correspondent E-mail

PLEASE DO NOT WRITE BELOW THIS LINE

License Number	Expiration Date	Date Received	Payment Amount

Instructions for Completing the OCal Certifier Registration Application

Please Type or Print your Application

New Applicant/Renewal Applicant: Place an (X) in the box next to New Applicant if your firm has not previously applied for an OCal Registration at this location while under the current ownership. Place an (X) in the box next to Renewal Applicant if your firm has already obtained an OCal Registration for this location and you are renewing that license. If this firm has changed location or ownership, please submit a new application for registration of that facility.

1. **Name of Firm:** Enter full name of business, corporation, company, or organization applying for licensure.
2. **DBA:** Enter any other name(s) your company is doing business as.
- 3.–5. **Facility Address:** Enter the number, street, city, state, and ZIP code for this facility location.
- 6.–8. **Mailing Address:** Enter the full mailing address if different from the facility address or P.O Box.
9. **Email:** Enter a contact email for the firm.
10. **Website:** Enter the website address for your business if applicable.
11. **Accreditation Status:** Place an (X) in the box that correctly describes accreditation status.
12. **Type of Ownership:** Place an (X) in the box next to the appropriate legal description of the facility's ownership.
13. **Owner's Name/Corporate Name:** Enter the owner's name here or (if applicable) the name of the corporation.
14. **Owners' or Officers' Names and Titles:** List the business owners' or officers' names and titles.
15. **Payment:** \$100.00 non-refundable registration fee. A penalty of 1.5 percent per month is due if the payment is submitted more than 30 days after the due date.
16. **Owner's Signature:** This section must be signed by the majority owner of the business to authorize not only the application, but the representatives and/or signatories whom they authorize to speak on behalf of the firm.
17. –18. **Authorized Representative and/or Signatories:** Enter contact information for the business operator and correspondent.

REGISTRATION FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE TO OTHER LOCATIONS OR ENTITIES

Please make all checks payable to: <u>CA Department of Public Health</u> Mail application and checks to:			
Regular Mail:	California Department of Public Health Food and Drug Branch – Cashier MS 7602 P.O. Box 997435 Sacramento, CA 95899-7435	Overnight Mail:	California Department of Public Health Food and Drug Branch – Cashier 1500 Capitol Avenue, MS-7602 Sacramento, CA 95814

Call the Food and Drug Branch at (800) 495-3232 if you have additional questions about this application.