



**TEXAS**  
Health and Human  
Services

Texas Department of State  
Health Services

M&D **OOS Milk**  
**Plant** 2003

**Budget** ZZ107  
**Fund** 114

License #

**BUSINESS FILING AND VERIFICATION SECTION**

**Out-of-State Milk Processing Plant  
Initial / Amended license application**

(Health and Safety Code, Chapter 435)

Return the completed application to:

Texas Department of State Health Services - Food & Drug Licensing,  
MC-2003 PO Box 149347, Austin, Texas 78714-9347

For Assistance call (512) 834-6727

**Plant Identification Code** Issued by Regulatory Agency (As shown in the IMS):

\_\_\_\_\_

(PL)(MA)

Name business is conducted under (DBA): \_\_\_\_\_

Physical address to be licensed: \_\_\_\_\_

\_\_\_\_\_  
City County ST Zip Code

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

**Inspection Fees:** Facilities located beyond the legal boundaries of the State of Texas, which export products into the State of Texas for sale or distribution shall be assessed a monthly inspection fee of \$.045 as stated in 25 Texas Administrative Code Chapter 217, Subchapter E, 217.91. Fees are assessed on a monthly basis and a minimum payment of \$5.00 is required. If a plant has no production and still maintains an active permit in the State of Texas, the facility will still be required to pay the minimum fee. The department may revoke a permit issued under Health and Safety Code 435, if the permit holder is delinquent in the remittance of the inspection fees.

**List of Products Distributed in Texas (attach a list if needed):**

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**Name(s), Address(es), Telephone number(s), of distribution point(s) in Texas (attach an additional list if needed).**

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**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, I am not currently delinquent in the payment of any corporation franchise taxes owed the State of Texas under chapter 171, Tax Health & Safety Code, nor am I delinquent in the payment of any child support owed under Chapter 232, Family Code. I further certify that I have read and understood Chapter 435 of the Health & Safety Code, and the applicable provisions of 25 TAC, Chapter 217, and agree to abide by them.

\_\_\_\_\_ Date: \_\_\_\_\_

Print name

\_\_\_\_\_  
Signature

**Title:**  Owner  President  Partner  Corporate Designee/Agent

**Purpose of this application:** Mark appropriate box to **indicate** purpose of this application and/or any changes in the status of firm.

**New** Estimated start date of regulated activity: \_\_\_\_\_

**Change in ownership:**

Previous company name: \_\_\_\_\_

License number (IMS#): \_\_\_\_\_

Effective date of change: \_\_\_\_\_

**Amended:**

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

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

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

Effective date of change: \_\_\_\_\_

Notice that firm is out of business. Date closed: \_\_\_\_\_

**Sign & date page 1 & return for deletion from our records.**

Not required to license. Reason: \_\_\_\_\_

**WEBSITE / INTERNET ADDRESS:** <http://www.> \_\_\_\_\_

**Mailing address information.** The license and inspection billing will be sent to the address below.

Mailing name: \_\_\_\_\_

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

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

Name of application preparer (contact person): \_\_\_\_\_

Telephone number of contact person: \_\_\_\_\_

Email address of contact person: \_\_\_\_\_

Fax number of contact person: \_\_\_\_\_

**License Holder Information:** Please list the 11 digit state Taxpayers Number on file with the Texas Comptroller of Public Accounts and the 9 digit 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 of sole owner: \_\_\_\_\_

**University/College**    **County/Department**    **Family Trust**

\_\_\_\_\_  
Name of entity

\_\_\_\_\_  
President / Officer

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

Effective date of partnership: \_\_\_\_\_

\_\_\_\_\_

Name of partnership

\_\_\_\_\_

Partner name

\_\_\_\_\_

Partner name

\_\_\_\_\_

Partner name

\_\_\_\_\_

**Corporation**     **LLC**

Date & Place of Incorporation: \_\_\_\_\_

Name of corporation: \_\_\_\_\_

President's name: \_\_\_\_\_

Officer name: \_\_\_\_\_

Officer name: \_\_\_\_\_

Name of registered agent: \_\_\_\_\_

**Privacy Notification:** With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You have the right to ask the state agency to correct any information that is determined to be incorrect.

You may visit our website at: [www.dshs.texas.gov/milk](http://www.dshs.texas.gov/milk)

**BE SURE TO COMPLETE ALL PAGES OF THIS FORM**