



State of Connecticut
Department of Agriculture
Bureau of Regulatory Services
 450 Columbus Boulevard, Suite 703
 Hartford, CT 06103
 Dairy Unit (860) 713-2508
 Licensing Unit (860) 713-2512

Permit # _____

NEW
 Fee Calculated Below

MILK LABORATORY PERMIT APPLICATION

In accordance with Section 22-150a of the Connecticut General Statutes, I (we) hereby apply for a permit to operate a Milk Laboratory and perform the procedures checked on this form. The initial permit shall be valid for remainder of the permitting year (July 1 through June 30th.) The permit may be renewed each year after the initial year. Laboratories must continually be found acceptable with annual or biennial evaluations, permits may be revoked for cause. Check or money order payable to the "CT Department of Agriculture" for the appropriate fee must accompany this application.

Applications cannot be processed if required payment is not submitted with the application or the application is incomplete. Incomplete applications and submitted payments will be returned for completion and resubmission. Permits are not transferable.

Please Print or Type	Federal Employer Identification Number _____ -- _____		
NAME OF LABORATORY	TELEPHONE NUMBER		
STREET ADDRESS	CITY/TOWN	STATE	ZIP CODE
MAILING ADDRESS (if different than home address)	CITY/TOWN	STATE	ZIP CODE

NAME OF DIRECTOR	TELEPHONE NUMBER	EMAIL ADDRESS
LABORATORY DIRECTOR'S SIGNATURE		DATE

CHECK ALL APPROPRIATE BOX(ES) BELOW

- CERTIFIED LABORATORY INHIBITOR TESTING (Appendix N official) \$20.00
- (--OR--)
- INHIBITOR SCREENING (Appendix N non-official) \$20.00
- MILK BACTERIA/DMSCC ANALYSIS \$20.00
- MILK COMPONENT/BUTTERFAT ANALYSIS \$20.00

(NEXT) Total Fee \$ _____

CHECK (✓) EACH BOX FOR THE PROCEDURE(S) TO BE TESTED AT LABORATORY

PROCEDURE

CHARM SL (APPENDIX N)	COLIFORM PLATE COUNT
IDEXX SNAP (APPENDIX N)	PETRIFILM COLIFORM COUNT/HIGH SENSITIVITY COLIFORM COUNT
STANDARD PLATE COUNT	PHOSPHATASE TEST – CHARM
PETRIFILM PLATE COUNT	PHOSPHATASE TEST – FLOUROPHOS
PLATE LOOP COUNT (RAW MILK ONLY)	DAIRY WATER
DELVO P 5 PACK	BUTTERFAT
DIRECT SOMATIC CELL COUNT	OTHER TEST – LIST
PASTEURIZED MILK CONTAINERS	OTHER TEST – LIST

The CT Dairy Laboratory Examination Officer or representative from the CT State Dept. of Agriculture must certify each laboratory and at least one analyst for each test that has been checked. Each analyst performing the tests must be licensed for the testing. Each analyst must hold a valid **MILK EXAMINER'S LICENSE**.

The undersigned applicant states that all of the information contained herein is true to the best of his/her knowledge and agrees that in the event a laboratory permit is granted, said applicant shall comply with all laws, orders, rulings, regulations and directive issued by the Commissioner of Agriculture.

PRINT NAME OF APPLICANT	SIGNATURE OF APPLICANT	DATE
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TITLE OF APPLICANT	TELEPHONE NUMBER	EMAIL ADDRESS
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AREA BELOW FOR OFFICE USE ONLY

Agency Approval _____ initials _____ date.

FEE AMOUNT RECEIVED	CHECK OR MONEY ORDER	DATE PROCESSED	TRANSMITTAL NUMBER	PERMIT EXPIRATION June 30, 2020
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