



TENNESSEE DEPARTMENT OF HEALTH
WIC/SENIOR FARMERS' MARKET NUTRITION PROGRAM

Initial Application: Yes ___ No ___

<p align="center">2023 FARMER APPLICATION FOR AUTHORIZATION TO PARTICIPATE IN THE TENNESSEE FMNP PROGRAM</p> <p align="center">Only completed applications will be processed.</p>	<p align="center">FOR FMNP USE ONLY</p> <p>REG. _____ CO. _____ FARMER NO. _____</p> <p>Agriculture Ext. Agent _____</p> <p>Date Contacted _____</p> <p>Vendor Rep _____</p> <p>Date Application Rec'd _____ Date Approved _____</p>
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Follow instructions and mail to the Regional Office. Complete in ink or type.

PART I. FARMER IDENTIFICATION

1. FARMER'S NAME _____

2. FARM NAME _____

A. MAILING ADDRESS

Street/P.O. Box _____ City _____ State _____ Zip _____

Telephone Number: Area Code _____ Number _____ Fax No. _____

E-mail address _____

B. FARM LOCATION (If different from above)

Street _____ Address/Rural _____ Route _____ Number _____

_____ City _____

_____ County(s) _____

_____ State _____ Zip _____

3. CROPS INTENDED TO GROW *(please list specific fruits and vegetables)* _____

4. LOCATION(S) OF MARKET(S) OR SELLING LOCATION(S)

Please list when and where you plan to sell produce.

LOCATION	DAY (Example M – F)	TIMES (Example 7 am – 6 pm)
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

5. SECONDARY CONTACT PERSON

Name of person in authority when (or if) farmer is not present:

First Name _____ Last Name _____

Street Number _____ Street Name/P.O. Box _____

City _____ State _____ Zip Code _____ Phone _____

PART III. CHECK REDEMPTION

6. BANK WHERE CHECKS WILL BE DEPOSITED (Don't leave this blank.)

Bank _____

Branch Name _____

PART IV. STATEMENTS AND CERTIFICATION

PRIVACY ACT STATEMENT - The collection of this information is authorized by Part 248.20 of Federal Regulations 7CFR which governs the FMNP Program and by Part 249.20 of Federal Regulations 7 CFR which governs the Senior FMNP. It will be used to determine whether a farmer qualifies to participate in the FMNP Program; to monitor compliance with program regulations; and for program management. However, failure to provide information may result in the denial or withdrawal of authorization to participate in the FMNP Program. The purpose of collection of this information is for audit and enforcement of FMNP Program regulations.

WARNING STATEMENT - Information in this application may be verified with other agencies. FMNP Program participation shall be denied or withdrawn if any application information is false; in addition, you may be fined up to \$10,000 or imprisoned for up to five years or both for concealing any material fact, making false statements or representation, or using any false writing or documentation in connection with the application.

CERTIFICATION AND SIGNATURE OF FARMER

- 1. I apply for authorization to take part in the FMNP Program, and I have authority to enter into an agreement with the Tennessee Department of Health.**
- 2. I understand that I will be responsible for understanding the requirements, policies, and procedures appearing in the Farmers' Market Handbook which is considered part of the Farmer's Agreement. This information shall be presented during both initial and follow-up training for authorization as a Farmers' Market Nutrition Program vendor. I further understand that I or another representative will have an opportunity to ask questions during the training sessions.**
- 3. I am at least 18 years of age, reside and grow the crops listed on this application in the state of Tennessee. The information contained in this application is accurate and complete. I understand that violation of the rules may result in the loss of my privilege to participate in the program. I understand that a FMNP representative may verify the information provided on my application by visiting my farm.**

SIGNATURE _____ **DATE** _____

PRINT NAME _____

DAYTIME PHONE NUMBER _____

COMPLETION OF THIS APPLICATION DOES NOT GUARANTEE AUTHORIZATION TO PARTICIPATE IN THE FMNP PROGRAM.

This institution is an equal opportunity provider.