



CONSUMER HEALTH SERVICE COMPLAINT FORM

Please check the Consumer Health Program that you wish to file a report on:

- FOOD/RESTAURANT, HOTEL/MOTEL, SANITARIAN, BODY PIERCING, TATTOO, RABIES/ANIMAL BITE, BEDDING, HEARING AID, MEDICAL MICROPIGMENTATION, OTHER, SMOKING, XRAY UNIT, POOL, MIDWIFE, GENETIC COUNSELOR, DRUG MANUFACTURING

**Name and contact information are kept as CONFIDENTIAL. To allow investigators an opportunity to follow-up or request additional information please include your name and contact information.

Name of Person Filing Complaint:
Mailing Address:
City State Zip
Email Address:
Primary Phone:

Complaint Against (Name): Lic# (if applicable):
Address/Location:
City State Zip
Nature of Complaint (Description): Phone:

(Please add additional pages as necessary to complete this information.)

OFFICIAL USE ONLY

Date Received: By: Date Referred:
Form: Telephone Letter Email Visit Source: Individual Other Gov't Agency Other:
Referred to: State/Central Office Local/County DEQ Municipality:
Other:
Referred To Mailing Address or Email Phone
Investigation Date: Follow-up Date(s): Complaint#:
By (Name/RS#): / County:
Investigation Data:
Evaluation & Final Outcome: