



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: 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: