

# RECORD OF COMPLAINT

Location of Complaint \_\_\_\_\_ Complaint Number \_\_\_\_\_

Received By \_\_\_\_\_ By  Letter  Telephone  In Person Date \_\_\_\_\_

Person responsible For Premises \_\_\_\_\_ Phone Number \_\_\_\_\_  
(Name) (Address)

Complaint \_\_\_\_\_ Phone Number \_\_\_\_\_  
(Name) (Address)

Representing Group or Agency \_\_\_\_\_ Phone Number \_\_\_\_\_  
(Name) (Address)

Specific Details Of Complaint \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is Another Agency Responsible ?  Yes  No \_\_\_\_\_ Jointly  Wholly   
(Name) (Address)

Date Agency Notified \_\_\_\_\_ By:  Letter  Telephone  In Person  Other \_\_\_\_\_  
To Be Investigated By \_\_\_\_\_ Date Assigned \_\_\_\_\_

## RESULTS OF INVESTIGATION

Was Complaint Justified?  Yes  No  
(Show Dates and Results of Investigation and Re-investigation Below)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Final Disposition:  Abatement  Referral \_\_\_\_\_  
Signature of Investigator Date

Other \_\_\_\_\_  
Signature of Health Director Date