



Health and Sanitation Complaint Form

Date Occurred: ___/___/___ Facility Name: _____ Time/Day of Meal/ Violation: _____

Complainant Name: _____ Age: _____ Gender: _____

Address: _____ Home Phone: _____ Cell Phone: _____

(1) Others in Party?	Name	Age	Gender
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(See last page for additional area to write if needed)

(2) Onset of symptoms: Date: _____ Time: _____ Duration of symptoms: _____

Symptoms: Nausea Diarrhea Fever Blurred Vision
 Vomiting Dizziness Headache Abdominal Cramps

Other: _____

(3) Was medical treatment sought? Yes No Duration of Hospitalization: _____

Doctor: _____ Doctor's phone number: _____

Hospital Address: _____ Hospital Phone: _____

(4) Suspected Food Item(s) and / or Manufacturer's Product Information: _____

Description of Meal/ Violation _____

Bag, Label, Date, and indicate current storage location of food: _____

(5) Leftover: Yes No If Yes, How was it kept? _____

(6) Other foods or beverages consumed/ incident (s) at the time of the suspected meal/ Violation.

Date/ Time	Location	Description
_____	_____	_____
_____	_____	_____

