



CONSUMER COMPLAINT REPORT

State Form 14993 (R3/6-04)

Health Department

INDIANA STATE DEPARTMENT OF HEALTH FOOD PROTECTION PROGRAM

[Empty box for additional information]

1. Bacterial Suspected Tampering Establishment
 Chemical Foodborne Illness Other _____
 Foreign Material Mislabeling _____

Date _____ Reported by _____ Phone _____

Complainant _____ Phone (H) _____ Phone (Other) _____

Address _____ City _____ State _____ Zip _____

Complaint

Injury/Illness Yes No If yes, symptoms _____

Date/Time of meal _____ Date/Time of symptoms _____ Number exposed _____ Number ill _____

Duration of illness _____ Physician/hospital _____ Address _____

2. Establishment Name _____ Food involved _____

Address _____ County _____ Date of visit _____ Time of Visit _____

3. Product label _____ Code/expiration date _____

Mfg. Name _____ Address _____ Pkg. size _____
 Dist. _____

Place of purchase _____ Address _____

Date of purchase _____ Number purchased _____ Number on hand _____

Police/firm notified _____ Contact _____

Additional info.

Sample collected Yes No Complaint taken by _____

ESTABLISHMENT FOLLOW-UP

Establishment name		Phone	
Person contacted		Title	
Action: <input type="checkbox"/> LHD <input type="checkbox"/> Retail <input type="checkbox"/> Wholesale <input type="checkbox"/> Other _____		Number on hand	Other complaints
Findings/comments			
Follow-up sample collected <input type="checkbox"/> Yes <input type="checkbox"/> No		Environmental Health Specialist	

Note: Complaint form should be used for initial complaint even if a sample is not involved. If a manufactured food product or foodborne illness is involved, please forward to ISDH.

INDIANA STATE DEPARTMENT OF HEALTH

Food Protection Program
 2 North Meridian Street
 Indianapolis, IN 46204

SAMPLE RELEASE DOCUMENT

I, _____ (Name) _____ (Street Address)
 _____ (City) _____ (State and Zip Code)

hereby agree to release the sample(s) described below into the custody of the authorized representative of the Food Protection Program, Indiana State Department of Health, for investigation and/or analysis:

 (Customer Signature) _____ (Date)

 (Food Protection Representative) _____ (Date)