Department of Health and Human Services
Office of Public Health Compliance

FOOD SAFETY INCIDENT FORM

Complainant Information *(Optional if filing anonymously)*

Name: _____ Phone Number: _____

Email Address: _____

Mailing Address: _____

Complaint Details

Date of Incident: _____ Time of Incident: _____

Name of Vendor or Establishment: _____

Location: _____

Describe Food Item(s) *(include what was seen and tasted)* _____

_____

_____

Was the issue reported to the business?

☐ Yes ☐ No If yes, who did you speak with? _____

Describe your symptoms

_____

_____

Date/time symptoms started: _____

Did you seek medical attention?

☐ Yes ☐ No If yes, where? _____

Was a stool sample or lab test completed?

☐ Yes ☐ No ☐ Unsure

Additional Information

Were photos, receipts, or samples of food saved?

☐ Yes ☐ No

Have you experienced similar incidences at this location before?

☐ Yes ☐ No

Other individuals who were present or affected:

_____

_____

For Office Use Only

Date Received: _____

Received By: _____

Follow- up conducted: ☐ Yes ☐ No Date: _____

Action(s) Taken:

_____

_____

Finding(s):

_____

_____