

LENAWEE COUNTY HEALTH DEPARTMENT

Record of Complaint

Address of Property Where Complaint is Located _____ Street _____ City _____ Zip Code _____

Telephone Number at Home Where Complaint is Located: _____

Name of Township Where Complaint is Located: _____ Tax ID#: _____

Name of Property OWNER Where Complaint is Located: _____

Address of Property OWNER: _____ Street _____ City _____ Zip Code _____

OWNER Phone Number _____

Complaint Regarding: Circle All That Apply

- 1. Water Supply 2. Sewage Disposal 3. Housing 4. Garbage/Refuse 5. Rodents 6. Insects 7. Chemicals 8. Hazardous Waste 9. Food Service 10. Other/Smoking

Date and Time violation observed: _____

Describe the Complaint: _____

If more space is needed, please attach an additional page.

Complainant

Name of Person Making Complaint: _____ Date: _____

Street Address: _____ City: _____

State: _____ Zip Code: _____ Telephone Number: (____) _____

Health Department Use Only- Do Not Write Below This Line

Preliminary Evaluation by: _____ Date: _____

[] Complaint is under the jurisdiction of another agency & was forwarded to: _____

[] Complaint is not valid. [] Complaint is valid & under the jurisdiction of this department.

Table with columns for Investigation, Correspondence, and Date. Rows include S.D. Letter #, Well Letter #, Complaint Letter#, and Other#.

Is complaint closed? [] Yes [] No [] N.A. (If so, please sign below)

HEALTH DEPARTMENT EMPLOYEE NAME

JOB TITLE

DATE

DATE: _____



