HEALTH DEPARTMENT COMPLAINT FORM

TOWN: RANDOLPH ☐ ROCKAWAY BORO ☐ DATE: _____

COMPLAINT: _____

LOCATION OF COMPLAINT: _____

NAME: _____

ADDRESS: _____ PHONE: _____

COMPLAINT REC'D: _____ 20 ___ TIME: _____ VERBAL PHONE MAIL

REC'D BY: _____ INSPECTOR: _____ DATE INSPECTED: _____ 20 ____

SUMMARY OF COMPLAINT:

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INVESTIGATION FINDINGS:

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ABATED: _____ 20 ____ NOTICE OF VIOLATION: _____ 20 ____