COMPLAINT REPORT FORM

Orange County Health Department
205 East Main Street, Paoli, IN 47454
PH. 812-723-7131 FAX 812-723-7117

Date_____

Name of person filing complaint (printed) _____

Phone Number of person filing the complaint_____

Address of person filing complaint_____
(INCLUDE CITY, STATE & ZIP)

Name of person or business complaint is against_____

Address of location complaint is against_____
(INCLUDE CITY, STATE & ZIP)

Have you contacted the person or business with your complaint? _____ If yes, list dates contact was made

and the names of persons contacted_____

_____

If not, why? _____

Please list all items concerning the complaint: (Please attach extra sheets if necessary)

_____

_____

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_____

I CERTIFY THAT ALL INFORMATION PROVIDED HEREIN AND ON ANY ATTACHMENTS ARE TRUE AND CORRECT.
I UNDERSTAND THAT IT IS A FELONY TO MISREPRESENT OR FALSIFY ANY PORTION OF THIS REPORT OR ATTACHED DOCUMENTS.

X_____Date_____
Signature of person filing complaint

NOTE: If you wish to obtain copies of any subsequent documents pertaining to this complaint, you may do so by a written request. According to The Access to Public Records Act, if an individual makes a request for information in person, by telephone, or e-mail, the public agency must respond within 24 hours of receipt of the request. If an individual makes a request for information by mail or facsimile, the public agency must respond within 7 calendar days of receipt of the request. **The Act requires only a response, and not the actual production of records, within a specified time period.** The Orange County Health Department will make every effort to produce the documents requested in a timely manner.