SERVICE REQUEST – INTAKE FORM  

Would you like the Kent City Health Department to contact you?

___ The inspector may contact me for more information.
___ I want to be contacted by the inspector with the results.
___ Please do not contact me about this request.
___ I would like to remain anonymous and will not automatically receive updates (Proceed to section II)

I. PERSON REPORTING INFORMATION (optional)

Name: __________________________________________________________

Phone ( ) ___________ - ___________ Email: ____________________________

Street Address: ____________________________________________________________________________________________________

City, State, Zip Code: ______________________________________________________________________________________________

II. FACILITY/HOME OWNER INFORMATION (location of concern)

Facility/Owner Name/Location: __________________________________________________________

Street Address/Intersection: ________________________________ Apt/Room #: _______________

Phone ( ) ___________ - __________________________

III. DETAILS (required information)

Date of incident (month/day/year) _______ / _______ / _______ Approximate Time _______ : _______ AM/ PM

What is the problem? (Be as descriptive as possible with who, what, when, where, why, and how)

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

How long has the problem been occurring?

What is the location of the problem (i.e. employee in kitchen not wearing gloves, Trash in the yard)?

_______________________________________________________________________________________

Are there dogs or other safety hazards the sanitarian needs to be aware of?

Have you notified the owner/manager of this issue? What was their response?

_______________________________________________________________________________________

Do you have any photos or other media you would like to share? Yes or No

Office Use only: Information verified [ ] Complaint entered into HealthSpace [ ] Supervisor was notified [ ]

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