

**KENT CITY HEALTH DEPARTMENT
COMPLAINT FORM**

NAME OF PARTY COMPLAINING: _____ PHONE: _____

ADDRESS OF COMPLAINANT: _____

EXACT LOCATION AND NATURE OF COMPLAINT: _____

If additional space is needed, please use the reverse side.

(DATE) _____ (SIGNATURE)

FOR OFFICE USE ONLY

Date Rec'd: _____ Defendant: _____

Inspector: _____ Address: _____

Date Comp: _____

REPORT

DATE: _____ ENTRY: _____ SIGNATURE _____

