#C _____

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**

Return to: Kent City Health Department
414 East Main Street P.O. Box 5192
Kent, OH 44240