



Bear River Health Department  
 Division of Environmental Health  
 85 East 1800 North  
 North Logan, UT 84341  
 Phone: 435-792-6570  
[www.brhd.org](http://www.brhd.org)

FOR OFFICE USE ONLY
Complaint #
Date Received
Complaint Taken By:
Referred To:

SECTION 1 – ESTABLISHMENT INFORMATION				
Name				
Address				
City	County		Zip Code	
Business Phone		License Number (if known)		
SECTION 2 – COMPLAINANT INFORMATION <i>(all personal information will be kept confidential)</i>				
Last Name	First	Middle	Title	Suffix
Organization Name (if representing an organization, please provide the name of the organization)				
CONTACT INFORMATION				
Primary Business Phone Number		Primary Home Phone Number		
Primary E-Mail Address		Alternate Phone Number or Fax Number		
Does the Complainant want to be contacted? <input type="checkbox"/> Yes <input type="checkbox"/> No				
MAILING ADDRESS				
Street Address or P.O. Box				
City	State	Zip Code (+4 optional)	Country	
SECTION 3 – DETAILS OF THE COMPLAINT				
Name of Ill Person				
Food(s) Eaten			Food was Eaten When:	
			Date	
Symptom(s) <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal Cramps <input type="checkbox"/> Chills <input type="checkbox"/> Other (specify in comments)			Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
			Symptoms Started:	
Name of Hospital or Physician (if applicable)			Date	
Comments (use the back if needed)			Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
			Symptoms Ended:	
			Date	
			Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
For additional ill persons, use next page. Please provide any additional comments on an addendum. If addendum is used, please check here <input type="checkbox"/> .				

**SECTION 4 – ADDITIONAL ILL PERSONS**

Name of Ill Person				
Food(s) Eaten		Food was Eaten When:		
		Date		
		Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	
Symptom(s) <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal Cramps <input type="checkbox"/> Chills <input type="checkbox"/> Other (specify in comments)		Symptoms Started:		
		Date		
Name of Hospital or Physician (if applicable)		Hospital/Physician Phone	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
Comments		Symptoms Ended:		
		Date		
		Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	

Name of Ill Person				
Food(s) Eaten		Food was Eaten When:		
		Date		
		Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	
Symptom(s) <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal Cramps <input type="checkbox"/> Chills <input type="checkbox"/> Other (specify in comments)		Symptoms Started:		
		Date		
Name of Hospital or Physician (if applicable)		Hospital/Physician Phone	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
Comments		Symptoms Ended:		
		Date		
		Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	

Name of Ill Person				
Food(s) Eaten		Food was Eaten When:		
		Date		
		Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	
Symptom(s) <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Headache <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal Cramps <input type="checkbox"/> Chills <input type="checkbox"/> Other (specify in comments)		Symptoms Started:		
		Date		
Name of Hospital or Physician (if applicable)		Hospital/Physician Phone	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
Comments		Symptoms Ended:		
		Date		
		Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	