Bear River Health Department
Division of Environmental Health
85 East 1800 North
North Logan, UT 84341
Phone: 435-792-6570
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 *(all personal information will be kept confidential)*

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? ☐ Yes ☐ 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	
	Time	☐ AM ☐ PM
Symptom(s) ☐ Nausea ☐ Diarrhea ☐ Fever ☐ Headache ☐ Vomiting ☐ Abdominal Cramps ☐ Chills ☐ Other (specify in comments)	Symptoms Started: Date	
Name of Hospital or Physician (if applicable) / Hospital/Physician Phone	Time	☐ AM ☐ PM
Comments (use the back if needed)	Symptoms Ended: Date	
	Time	☐ AM ☐ PM

For additional ill persons, use next page. Please provide any additional comments on an addendum. If addendum is used, please check here ☐.

SECTION 4 – ADDITIONAL ILL PERSONS

Name of Ill Person

Food(s) Eaten

Food was Eaten When:
Date
Time ☐ AM ☐ PM

Symptom(s)
☐ Nausea ☐ Diarrhea ☐ Fever ☐ Headache
☐ Vomiting ☐ Abdominal Cramps ☐ Chills ☐ Other (specify in comments)

Symptoms Started:
Date
Time ☐ AM ☐ PM

Name of Hospital or Physician (if applicable)

Hospital/Physician Phone

Comments

Symptoms Ended:
Date
Time ☐ AM ☐ PM

Name of Ill Person

Food(s) Eaten

Food was Eaten When:
Date
Time ☐ AM ☐ PM

Symptom(s)
☐ Nausea ☐ Diarrhea ☐ Fever ☐ Headache
☐ Vomiting ☐ Abdominal Cramps ☐ Chills ☐ Other (specify in comments)

Symptoms Started:
Date
Time ☐ AM ☐ PM

Name of Hospital or Physician (if applicable)

Hospital/Physician Phone

Comments

Symptoms Ended:
Date
Time ☐ AM ☐ PM

Name of Ill Person

Food(s) Eaten

Food was Eaten When:
Date
Time ☐ AM ☐ PM

Symptom(s)
☐ Nausea ☐ Diarrhea ☐ Fever ☐ Headache
☐ Vomiting ☐ Abdominal Cramps ☐ Chills ☐ Other (specify in comments)

Symptoms Started:
Date
Time ☐ AM ☐ PM

Name of Hospital or Physician (if applicable)

Hospital/Physician Phone

Comments

Symptoms Ended:
Date
Time ☐ AM ☐ PM