OKLAHOMA State Department of Health

Consumer Health / OK State Dept. of Health
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CONSUMER HEALTH SERVICE COMPLAINT FORM

Please check the Consumer Health Program that you wish to file a report on:

☐FOOD/RESTAURANT	☐ RABIES/ANIMAL BITE	☐ SMOKING	☐ XRAY UNIT
☐HOTEL/MOTEL	☐ BEDDING	☐ POOL	☐ MIDWIFE
☐SANITARIAN	☐ HEARING AID		☐ GENETIC COUNSELOR
☐BODY PIERCING	☐ MEDICAL MICROPIGMENTATION		☐ DRUG MANUFACTURING
☐TATTOO	☐ OTHER: _____		

***Name and contact information are kept as **CONFIDENTIAL**. To allow investigators an opportunity to follow-up or request additional information please include your name and contact information.*

Name of Person Filing Complaint: _____

Mailing Address: _____
Address

_____ _____ _____
City State Zip

Email Address: _____

Primary Phone: _____

Complaint Against (Name): _____ Lic# (if applicable): _____

Address/Location: _____

_____ _____ _____
City State Zip

Nature of Complaint (Description): Phone: _____

(Please add additional pages as necessary to complete this information.)

OFFICIAL USE ONLY

Date Received: _____ By: _____ Date Referred: _____

Form: ☐ Telephone ☐ Letter ☐ Email ☐Visit Source: ☐Individual ☐Other Gov't Agency ☐Other: _____

Referred to: ☐State/Central Office ☐ Local/County ☐ DEQ ☐ Municipality: _____

☐Other: _____ _____ _____
Referred To Mailing Address or Email Phone

Investigation Date: _____ Follow-up Date(s): _____ Complaint#: _____

By (Name/RS#): _____ / _____ County: _____

Investigation Data: _____

Evaluation & Final Outcome: