



MARION PUBLIC HEALTH

Making Marion a healthier place to live, work, and play

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COMPLAINT FORM

Please print or type the information needed below:

Name of Complainant: _____ Date: _____

Address: _____ Phone: _____

Location of Complaint: _____

Name of person complaint is against: _____

Address: _____

Type of Complaint: _____

(use back if more space if needed)

Signature of Complainant

- HEALTH DEPARTMENT USE ONLY -

Complaint Number: _____

Investigator: _____ Date: _____

Findings: _____

Type of Notice given: _____ Written _____ Verbal _____ Posting

Date reinspection made: _____ By: _____

Findings: _____
