LEE COUNTY HEALTH Department

Public Health
Prevent. Promote. Protect.

Serving Lee County Since 1947

LCHD BUSINESS COMPLAINT FORM

(Please type or print in ink legibly)

_____ _____

Establishment Name (please print) Establishment Address

_____ _____

Incident Date Incident Time

Nature of Complaint: (please provide as much detail as possible, use an additional sheet if necessary)

_____

_____

_____

Did you contact the establishment about the problem: ( )No ( ) Yes, if yes date: _____/_____/_____

Can we contact you for any questions or clarification on the complaint? ( ) No ( )Yes, if yes:

_____ (_____) _____ - _____

Name Phone Number

_____ _____

Address Email

Submission of a false statement to a public official, pursuant to CIVIL LIABILITIES (740 ILCS 175/) Illinois False Claims Act, constitutes a misdemeanor of the third degree of offense, punishable by a fine and imprisonment of not more than one year.

_____ _____/_____/_____

Signature Date

Please return the complaint to Lee County Health Department: ehfaxes@lchd.com, Fax: (815)288-1811, Mail: LCHD, 309 South Galena Ave. Suite 100, Dixon, IL 61021.

This form must be used to register a complaint with Lee County Health Department. If you have questions, please contact us by phone at (815)284-3371.

FOR OFFICE USE ONLY:

Inspector_____Received_____/_____/_____Completed_____/_____/_____