

DBPR HR-7004 – Division of Hotels and Restaurants Foodborne Illness Complaint Form

STATE OF FLORIDA
DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION
 1940 North Monroe Street
 Tallahassee, FL 32399-1011
 Phone: 850.487.1395
Call.Center@dbpr.state.fl.us
www.MyFloridaLicense.com/dbpr/hr

FOR OFFICE USE ONLY
Complaint #
Date Received

SECTION 1 – ESTABLISHMENT INFORMATION						
Name						
Address						
City		County		Zip Code		
Business Phone			License Number (if known)			
SECTION 2 – COMPLAINANT INFORMATION						
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:		Date	
Name of Hospital or Physician (if applicable)			Hospital/Physician Phone		Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
Comments						
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"/> .						

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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				

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				

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				