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

## STATE OF FLORIDA DEPARTMENT OF BUSINESS AND PROFESSIONAL REGULATION 2601 Blair Stone Road Tallahassee, FL 32399-1011

Phone: 850.487.1395

http://www.myfloridalicense.com/contactus/

www.myfloridalicense.com/DBPR/hotels-restaurants/

FOR OFFICE USE ONLY
Complaint #
Date Received

SECTION 1 – ESTABLISHMENT INFORMATION							
Name							
Address							
City		County			Zip Code		
Business Phone			License Number (if kı	nown)			
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 Num	ber		Primary Home Phone	Number			
Primary E-Mail Address			Alternate Phone Number or Fax Number				
Does the Complainant want to be contacted?							
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				F	ood was Eaten When:		
( )					ate		
				Т	ime AM		
Symptom(s)				S	ymptoms Started:		
☐ Nausea ☐ Diarrhea	a ☐ Fev nal Cramps ☐ Chi		Headache Other (specify in comm	D	ate		
Name of Hospital or Physician	•		Hospital/Physician F		ime AM		
Comments							
For additional ill persons, use next page. Please provide any additional comments on an addendum. If addendum is							
used, please check here .	next page. Please pro	ovide any	additional comments (	on an addei	naum. It addendum is		

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Name of Ill Person  Food(s) Eaten  Symptom(s)  Nausea Diarrhea Fever Headache Vomiting Abdominal Cramps Chills Other (specify in comments)  Name of Hospital or Physician (if applicable) Hospital/Physician Phone	Food was Eaten When: Date  Time AM PM  Symptoms Started: Date  Time AM PM
Symptom(s)  Nausea Diarrhea Fever Headache Vomiting Abdominal Cramps Chills Other (specify in comments)	Date  Time
<ul><li>☐ Nausea</li><li>☐ Diarrhea</li><li>☐ Fever</li><li>☐ Headache</li><li>☐ Other (specify in comments)</li></ul>	Time AM PM Symptoms Started: Date Time AM
<ul><li>☐ Nausea</li><li>☐ Diarrhea</li><li>☐ Fever</li><li>☐ Headache</li><li>☐ Other (specify in comments)</li></ul>	Symptoms Started: Date  Time
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Traine of Freepital of Freepital (in applicable)	, <del>_</del>
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	Date
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Comments	
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Comments	

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