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 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? ☐ Yes ☐ 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 / Time ☐ AM ☐ PM
Symptom(s) ☐ Nausea ☐ Diarrhea ☐ Fever ☐ Headache ☐ Vomiting ☐ Abdominal Cramps ☐ Chills ☐ Other (specify in comments)	Symptoms Started: Date
Name of Hospital or Physician (if applicable) / Hospital/Physician Phone	Time ☐ AM ☐ PM

Comments

For additional ill persons, use next page. Please provide any additional comments on an addendum. If addendum is used, please check here ☐.

SECTION 4 – ADDITIONAL ILL PERSONS

Name of Ill Person

Food(s) Eaten

Food was Eaten When:
Date
Time ☐ AM ☐ PM

Symptom(s)
☐ Nausea ☐ Diarrhea ☐ Fever ☐ Headache
☐ Vomiting ☐ Abdominal Cramps ☐ Chills ☐ Other (specify in comments)

Symptoms Started:
Date

Name of Hospital or Physician (if applicable)

Hospital/Physician Phone

Time ☐ AM ☐ PM

Comments

Name of Ill Person

Food(s) Eaten

Food was Eaten When:
Date
Time ☐ AM ☐ PM

Symptom(s)
☐ Nausea ☐ Diarrhea ☐ Fever ☐ Headache
☐ Vomiting ☐ Abdominal Cramps ☐ Chills ☐ Other (specify in comments)

Symptoms Started:
Date

Name of Hospital or Physician (if applicable)

Hospital/Physician Phone

Time ☐ AM ☐ PM

Comments

Name of Ill Person

Food(s) Eaten

Food was Eaten When:
Date
Time ☐ AM ☐ PM

Symptom(s)
☐ Nausea ☐ Diarrhea ☐ Fever ☐ Headache
☐ Vomiting ☐ Abdominal Cramps ☐ Chills ☐ Other (specify in comments)

Symptoms Started:
Date

Name of Hospital or Physician (if applicable)

Hospital/Physician Phone

Time ☐ AM ☐ PM

Comments