

CONSUMER COMPLAINT/ILLNESS FORM

Complaint Number: _____

Quality Related: Food Safety Related: Unknown:

Date: _____ Time Reported: _____ am pm

Customer Name: _____ Phone: _____(H) _____(W)

Address: _____ City: _____

State/Province: _____ Zip Code: _____

Email: _____

Product Consumed:

Product Name: _____ Size: _____

Code on Package: _____ UPC: _____

Location Purchased: _____

Date Purchased: _____ Date Consumed: _____

How was the Product Stored? _____

Nature of Complaint:

Foreign Object Off Flavor Unsatisfactory Flavor

Packaging Illness or Injury Allergic Reaction

Other Specify: _____

How Many People Consumed? _____ Ages? _____

Symptoms/Additional Problem Information: _____

Has the customer:

Seen a Doctor YES NO Details: _____

Spoken to Public Health YES NO Details: _____
(local Health Unit)

Gone to the Hospital YES NO Details: _____

Contacted Regulatory Agency YES NO Details: _____

Complaint Received By:

SIGN

PRINT NAME

DATE