INSTRUCTIONS:

TO SUBMIT A COMPLAINT PLEASE FILL IN THE ATTACHED FORM TO THE BEST OF YOUR ABILITY.

FOOD SERVICE RELATED COMPLAINTS ARE THE ONLY COMPLAINTS WE CAN TAKE ANONYMOUSLY.

ALL OTHER COMPLAINTS MUST INCLUDE YOUR NAME, ADDRESS, AND PHONE NUMBER IN THE COMPLAINANT SECTION

ONCE COMPLETED YOU MAY SUBMIT YOUR COMPLAINT FORM TO OUR DEPARTMENT BY:

EMAIL: EHDESK@LENAWEE.MI.US

FAX: 517-264-0790

MAIL:
LENAWEE COUNTY HEALTH DEPARTMENT
1040 S. WINTER ST.
SUITE 2328
ADRIAN, MI 49221

IN-PERSON:
OUR OFFICE HOURS ARE MONDAY - FRIDAY 8AM to 12PM & 1PM to 4:30PM

QUESTIONS? PLEASE GIVE US A CALL:

WELL AND SEPTIC COMPLAINTS: 517-264-5214

ALL OTHER COMPLAINTS: 517-264-5213

LENAWEE COUNTY HEALTH DEPARTMENT

Record of Complaint

Address of Property Where Complaint is Located _____
Street City Zip Code

Telephone Number at Home Where Complaint is Located:_____

Name of Township Where Complaint is Located:_____ ***Tax ID#:*** _____

*Name of Property **OWNER** Where Complaint is Located*:_____

*Address of Property **OWNER***:_____
Street City Zip Code

***OWNER** Phone Number*_____

Complaint Regarding:
Circle All That Apply

1. Water Supply ☐
2. Sewage Disposal ☐
3. Housing ☐
4. Garbage/Refuse ☐
5. Rodents ☐
6. Insects ☐
7. Chemicals ☐
8. Hazardous Waste ☐
9. Food Service ☐
10. Other/Smoking ☐

Date and Time violation observed: _____

Describe the Complaint:

If more space is needed, please attach an additional page.

Complainant

Name of Person Making Complaint:_____ Date:_____

Street Address:_____ City:_____

State:_____ Zip Code:_____ Telephone Number: (_____)_____

Health Department Use Only- Do Not Write Below This Line

Preliminary Evaluation by:_____ Date:_____

☐ Complaint is under the jurisdiction of another agency & was forwarded to:_____

☐ Complaint is not valid. ☐ Complaint is valid & under the jurisdiction of this department.

Investigation:

Correspondence:

		Date:
S.D. Letter #		
Well Letter #		
Complaint Letter#		
Other#		

Is complaint closed? ☐ Yes ☐ No ☐ N.A. (If so, please sign below)

_____ _____ _____
HEALTH DEPARTMENT EMPLOYEE NAME JOB TITLE DATE