



Ashland County Health Department

Complaint Submission Form

Date: _____ Location: _____

Offender: _____ Address if Known: _____

Nature of Complaint: _____

Complainant: _____ Address: _____

Phone #: _____ E-mail: _____

***** OFFICE USE ONLY*****

ID#: _____ Received: _____ Type: _____ P.S. _____

Referred to: _____ By: _____

Date of Investigation: _____ Recheck Date(s): _____

Findings & Actions: _____

Date Completed: _____ Final Disposition: _____

Orders Issued: Y___ N___ Date: _____ Due: _____

Investigator Signature: _____

Revised: June 2023