



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF COMMUNICABLE DISEASE CONTROL & PREVENTION
FOOD PRODUCT COMPLAINT RECORD

Mail or Fax Completed Form to: Missouri Department of Health and Senior Services, Bureau of Environmental Regulations and Licensure, P.O. Box 570, Jefferson City, Missouri 65102. Our fax number is (573) 526-7377. Our toll free phone number is (866) 628-9891.

1. DATE AND COUNTY OF COMPLAINT

MM/DD/YYYY COUNTY

2. FORM OF COMPLAINT

☐ TELEPHONE ☐ LETTER ☐ VISIT ☐ INTERNET/E-MAIL

3. SOURCE OF COMPLAINT

☐ CONSUMER ☐ LOCAL ☐ FEDERAL
☐ GOVERNMENT ☐ STATE ☐ OTHER

4. COMPLAINT IDENTIFICATION

A. NAME ADDRESS (INCLUDE ZIP CODE)

B. HOME TELEPHONE NUMBER WORK TELEPHONE NUMBER E-MAIL ADDRESS
() ()

5. COMPLAINT OR INJURY

A. TYPE OF COMPLAINT
☐ PRODUCT (complete Section 7 and 8)
☐ FOOD SERVICE ESTABLISHMENT (complete section 8)
B. DESCRIBE THE COMPLAINT

C. DOES COMPLAINANT EXPECT ADDITIONAL FDA CONTACT?
☐ YES ☐ NO

6. INJURY OR ILLNESS RESULTED

A. ☐ YES ☐ NO (If "yes" complete items B through F)

B. SYMPTOMS
☐ Vomiting Onset Date/Time ☐ Skin/Eye Irr Onset Date/Time ☐ Headache Onset Date/Time
☐ Fever °F Onset Date/Time ☐ Nausea Onset Date/Time ☐ Chills Onset Date/Time
☐ Abdominal Cramps Onset Date/Time ☐ Diarrhea Onset Date/Time
☐ Dizzy/Blurred Vision Onset Date/Time ☐ Other Onset Date/Time

C. TIME PRODUCT USED/CONSUMED D. FURTHER ACTION TAKEN
☐ YES ☐ NO (If "yes" describe action in "Remarks" section.)

E. TREATED AT THOSPITAL EMERGENCY ROOM
☐ YES ☐ NO (If "yes" give hospital name, address, phone numbers, dates and names of persons treated.)
LABORATORY SPECIMEN TAKEN ☐ YES ☐ NO
F. MEDICAL CONSULTATION (other than Emergency Room)
☐ YES ☐ NO (If "yes" give name, address, phone number, date and names of persons treated.)

7. PRODUCT AND LABELING

A. NAME AND LOCATION OF STORE WHERE PURCHASED

B. SIZE AND TYPE OF PACKAGE C. PRODUCT NAME
D. PACKAGE CODE/SERIAL NUM / ETC. E. DATE PURCHASED (MM/DD/YYYY) F. PRODUCT USED (IF "YES" ENTER DATE) G. AMOUNT OF PRODUCT REMAINING
☐ YES ☐ NO
H. UPC CODE INFORMATION I. UNOPENED PRODUCT AVAILABLE
☐ YES ☐ NO

8. PREPARER, MANUFACTURER/DISTRIBUTOR OF PRODUCT

A. NAME AND LOCATION OF FIRM (INCLUDE ZIP CODE)

INCLUDE PHONE NUMBER IF AVAILABLE

9. REMARKS (ATTACH ADDITIONAL PAGES IF NECESSARY)

NAME AND TITLE/EPHS NUMBER AGENCY NAME AND TELEPHONE NUMBER DATE



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF COMMUNITY AND PUBLIC HEALTH
FOOD PRODUCT COMPLAINT

INSTRUCTIONS

1. **Date and County of Complaint:** Date the complaint was received by the reporting agency and the county the complaint originated.
2. **Form of Complaint:** Was the complaint received by telephone, letter, e-mail, or personal visit to the reporting agency.
3. **Source of Complaint:** Was the source a Government Agency, state, local, federal; a consumer or other. Check all that apply.
4. **Complainant Identification:** Name address, zip code and telephone numbers of the person delivering the complaint.
5. **Complaint or Injury:**
 - A. Check if the complaint is a product purchased or a Food Service Establishment visited by the complainant. Food Service Establishment; restaurant, convenience store, grocery store, etc.
 - B. Give a brief description of the complaint (taste, odor, object found in product etc.). If a restaurant list all products eaten at the time of visit.
 - C. Check if the complainant wants to be contacted by FDA, USDA, but only if the product is under FDA/USDA jurisdiction.
6. **Injury or Illness:**
 - A. Yes or No if an injury or illness occurred as a result of the use of the product in question.
 - B. Check the predominate symptoms and give the date and time of onset. If a fever, list the highest temperature.
 - C. Date and time the product was used or the establishment was visited.
 - D. Was further action taken by the reporting agency related to the complaint (an inspection of the establishment, an Epidemiological investigation, etc.). If yes describe the action briefly in the "Remarks" section.
 - E. Was anyone treated at a hospital Emergency Room? If No continue to F, if yes give the date, name, address and telephone number of the hospital and the name(s) of the person(s) hospitalized if known, use additional sheets if necessary. Did the ER collect any laboratory specimens Blood, stool, etc.? Check Yes or No.
 - F. If no one was hospitalized did anyone consult a physician, nurse practitioner, nursing hotline, or other medical professional as a result of the complaint? If NO, continue to number 7. If yes give the date(s), name, address, and telephone number of the medical professional; and the name(s) of the person(s) seen. Were laboratory specimens collected? Check Yes or No.
7. **Product Labeling:**
 - A. Give the name and address of the store where the product was purchased.
 - B. Give the size and type of package (example; 24 oz card board box, 12 oz plastic bottle).
 - C. Give the product Name as it appears on the label.
 - D. List any package code, serial numbers, plant codes, that are printed on the original package.
 - E. Date purchased.
 - F. Product used, if "yes" give the date used.
 - G. Give the amount of product remaining in the original package.
 - H. Give the UPC code as it is written on the original package.
 - I. Is there any unopened product, with the same Lot codes, available either at the store where purchased, with the complainant, or at another location. List where product is located.
8. **Prepare, Manufacturer/Distributor:** Give the name, address, zip code and telephone number (if known) of:
The restaurant where the product was prepared if complaint is about food items in a restaurant;
The manufacturer of the product as stated on the product label, or
The distributor of the product (if known).
9. **Remarks:** Give any additional information regarding the complaint. Use additional pages if necessary.

**Complete the form and fax it to the Bureau of Environmental Licensure and Regulation (573) 526-7377.
For questions you can call the toll free number (866) 628-9891.**