Consumer Complaint Form

Wisconsin Division of Food Safety

Please fill in as much information as possible.
You will be contacted by a DFS staff member who will review this complaint with you.

Your name: Today's date:
Your address:

Home telephone number: Best time to contact:
Work telephone number:

Please briefly describe your food safety complaint:

Were you or someone you know injured or made sick by this food? ☐ No ☐ Yes

If yes, mark any of the following symptoms that are or were present:

☐ Vomiting ☐ nausea ☐ diarrhea ☐ fever

☐ skin or eye irritation ☐ headache ☐ other (please describe below)

If yes, did you or a family member get medical attention for the illness?

☐ No ☐ Yes

If yes, please give the name, address and telephone number of the health care professional who attended:

Were you or a family member hospitalized due to the illness? ☐ No ☐ Yes

If yes, please give the name, address and telephone number of the hospital or clinic:

Have you or a family member contacted public health authorities (local or state)?

☐ No ☐ Yes

If yes, when?:

_____

Did you buy the food mentioned in the complaint above? ☐ No ☐ Yes

If yes, please give any or all of the following information about the food product:

Brand name:

Product name:

Size & package type:

Lot or serial number:

Expiration or use-by date:

Date you purchase it:

Name and location of store where purchased:

Is there any of the product remaining? ☐ No ☐ Yes
If yes, how much and where is it stored?

When you are finished, please mail this form as soon as possible to:

Division of Food Safety
Wisconsin DATCP
P.O. Box 8911
Madison, WI 53708-8911