COMPLAINT FORM

Office of Community Development
Health Division
1625 Massachusetts Avenue
Lexington, MA 02420

(781) 862-0500

Person Registering the Complaint _____ or anonymous.

DATE _____

Complainant's Address_____

Complaint Description

NAME _____

ADDRESS_____

COMPLAINT_____

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Report Notes / Inspection Follow Up

DATE_____

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PERSON RECEIVING INFORMATION_____

COMPLIANCE
DATE_____INSPECTORS
SIGNATURE_____