



Central  
Connecticut  
Health  
District

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PUBLIC HEALTH for BERLIN, NEWINGTON, ROCKY HILL, & WETHERSFIELD

## COMPLAINT FORM

(e-mail, fax or mail to address above)

Date \_\_\_\_\_

\* Site of Complaint (Street Address) \_\_\_\_\_

\* Town \_\_\_\_\_

Owner of Site \_\_\_\_\_ Tel. \_\_\_\_\_

Address (if different from site of complaint) \_\_\_\_\_

\* Problem (Be Specific):

\* Complainant's Name \_\_\_\_\_

\* Complainant's Address \_\_\_\_\_

\* Complainant's Telephone: Home \_\_\_\_\_

Work \_\_\_\_\_

Cell \_\_\_\_\_

\* Required Field