

**COMPLAINT OF HUMAN EXPOSURE OR UNSAFE CONDITION**

PR-ENF-074 (EST. 9/94)

COMPLAINANT'S NAME		TELEPHONE NUMBER (Include area code) (    )	
ADDRESS	CITY	STATE	ZIP CODE

DATE OCCURRED	NUMBER OF PERSONS EXPOSED TO CONDITION:	IS EXPOSURE CONTINUING ? YES <input type="checkbox"/> NO <input type="checkbox"/>	WAS A DOCTOR SEEN? YES <input type="checkbox"/> NO <input type="checkbox"/>	DOCTOR'S TELEPHONE (include area code) (    )
DOCTOR'S NAME			DOCTOR'S ADDRESS	

LOCATION OF EXPOSURE OR CONDITION (Be specific)

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	COUNTY
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DESCRIPTION OF EXPOSURE OR CONDITION

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NAME OF PESTICIDE/MANUFACTURER	REGISTRATION NUMBER FROM LABEL
DOSE/DILUTION/VOLUME	COMMODITY/SITE TREATED
NAME OF PERSON OR FIRM ALLEGEDLY RESPONSIBLE	OWNER OR OPERATOR OF PROPERTY TREATED
OCCUPATIONAL SITUATION YES <input type="checkbox"/> NO <input type="checkbox"/>	OCCUPATION

<p><b>Important!</b> You do not need to complete this portion of the form unless the complaint is the result of an occupational situation.</p>	EMPLOYER'S NAME		TELEPHONE NUMBER (Include area code) (    )	
	ADDRESS		CITY	
	TYPE OF BUSINESS		STATE	
	SUPERVISOR'S NAME		ZIP CODE	
	TITLE			
	COMPLAINANT IS: <input type="checkbox"/> FORMAL <input type="checkbox"/> INFORMAL			
EMPLOYEE CONFIDENTIALITY PURSUANT TO SECTION 6309 OF THE LABOR CODE:		I PERMIT THE DISCLOSURE OF MY NAME		YES <input type="checkbox"/> NO <input type="checkbox"/>
		I PERMIT THE DISCLOSURE OF THIS INFORMATION		YES <input type="checkbox"/> NO <input type="checkbox"/>

*I hereby certify that the above, to the best of my knowledge, is true and correct.*

CLAIMANT'S SIGNATURE 	DATE
PERSON RECEIVING THE COMPLAINT (Print name)	DATE
TITLE	

**Complainant: This form must be signed and dated prior to submission.**