FLOYD COUNTY HEALTH DEPARTMENT

1917 Bono Road
New Albany, Indiana 47150-4607
Telephone (812) 948-4726
Fax (812) 948-2208
www.floydcountyhealth.org

DATE: _____

PROPERTY ADDRESS: _____

_____

(CITY) (STATE) (ZIP)

PROPERTY OWNER: _____ _____
(NAME) (PHONE)

OWNER ADDRESS: _____
(CITY) (STATE) (ZIP)

DESCRIPTION OF COMPLAINT: _____

_____

_____

COMPLAINANT: _____ _____
(NAME) (PHONE)

COMPLAINANT ADDRESS: _____
(CITY) (STATE) (ZIP)

OWNER ADDRESS: _____
(IF DIFFERENT FROM PROPERTY) (CITY) (STATE) (ZIP)

OCCUPANT/TENANT:_____ _____
(IF DIFFERENT FROM OWNER) (NAME) (PHONE)

I, the undersigned, do now affirm under penalties of Perjury that the foregoing information and/or representations are true.

Signature: _____
(COMPLAINANT) (DATE)

***A person who provides false information upon which a health officer relies in issuing an order Under IC 16-20-1-25 commits a Class C infraction.*