

# SMOKING COMPLAINT FORM

Date: \_\_\_/\_\_\_/\_\_\_

Please fill out this form with as much information as you have. If you do not know the answer to a question, leave it blank. If you would like to remain anonymous, please call the Tobacco Related Disease Control Program office at (415) 499-3020 and we will take your complaint over the phone.

## COMPLAINT

Date Smoking Observed \_\_\_/\_\_\_/\_\_\_ Time Smoking Observed: \_\_\_\_\_ am \_\_\_\_\_ pm

### Type of Establishment

Your Name (let us know if you prefer confidentiality) \_\_\_\_\_

Your Email address: \_\_\_\_\_

Your Phone number: \_\_\_\_\_

Where did the incident occur?

OFFICE BUILDING     BAR     RESTAURANT     TRANSIT SHELTER  
 OTHER \_\_\_\_\_

NAME OF ESTABLISHMENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

ZIP CODE: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

NAME OF CONTACT (Owner or manager, if known) \_\_\_\_\_

Please describe your complaint **and/or** check boxes below:

1. How many people were smoking in non-smoking area \_\_\_\_\_
2. Were any employees/patrons smoking inside the establishment?     Yes     No
3. Were any employees/patrons smoking in other non-smoking areas such as within 20 feet of doors and windows?     Yes     No
4. Were appropriate "No Smoking" signs posted?     Yes     No
5. Was the owner present while people were smoking?     Yes     No

Please Describe your observations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your Name: \_\_\_\_\_ Your Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Your Phone number: Work: \_\_\_\_\_ Home: \_\_\_\_\_

Email address: \_\_\_\_\_

Do you wish to be contacted about this complaint? Yes \_\_\_\_\_ No \_\_\_\_\_