TEL NO.

CFN:

FEI:

Commonwealth of Virginia
Food Safety and Security Program
Department of Agriculture and Consumer Services
P.O. Box 1163
Richmond, Virginia 23218

CL:

REG FU:

NEXT IN:

BY:

INSPECTION REPORT

TO: _____
(Owner or Operator) (Title) (Date)

_____ , , Virginia,
(Firm Name) (Address)

During an inspection of your _____ on _____
the following objectionable conditions were observed:

Inspection Report left with _____ by _____ Inspector # _____
Name Title

_____ Adulterated food items listed in observations _____ were destroyed with my consent.

_____ Witnessed the collecting, marking, or sealing of samples _____

☐ Portion of Sample was left with vendor ☐ Vendor did not desire portion of sample ☐ Pictures Price Paid: $

_____

Rdnts ☐ Insts ☐ Dirty Eq ☐ Dirty Pr ☐ Misbrnd ☐ Pest Mis ☐ Fat Decl ☐ Inf Form ☐ App Lw ☐ Egg Lw ☐

Sanit ☐ Tmp Hot ☐ Tmp Cold ☐ Emp Prac ☐ Unp Food ☐ Sel Serv Sup ☐ Bldg ☐ Equip ☐ Plumb ☐ Adult Fd ☐

Private Water/Sewer ☐ Public Water/Sewer ☐

Name Change ☐ Add Change ☐ Nw Frm ☐ Food Svc ☐ HD Inspns ☐ Frz Des ☐ Home Op ☐ New Owner ☐ Wholesale ☐ Retail ☐

INSPECTION TYPE	BASIS OF INSPECTION
State ☐ Contract ☐	Routine ☐ Compliance ☐ Complaint ☐

Product	FDA #	Action Taken	Lbs	P-#	Lot Code	Problem w/Product

SPECIAL CIRCUMSTANCES/CONDITIONS

Audit Inspection ☐	FDA Audit Inspection ☐	Diet Supplements ☐	Disaster/Fire ☐	Recall Check ☐		

RISK ASSESSMENT

	High ☐	Medium ☐	Low ☐	

	Product destroyed by management WITHOUT the Inspector's request in the following observation(s):	

The above item does not require the signature of management and is NOT included in the voluntary destruction section of the Inspection Report

Commonwealth of Virginia
Department of Agriculture & Consumer Services
FOOD SAFETY & SECURITY PROGRAM
P.O. Box 1163
Richmond, VA 23218
SAMPLE COLLECTION REPORT

DCLS LAB USE ONLY

11857	☐ **Roanoke Regional Office**	**210 Church Street, SW, Suite 360**	**540-857-7344**	**Roanoke, VA 24001**	☒ **248**	**Food**
3211	☐ **Richmond Central Office**	**1100 Bank Street**	**804-786-3520**	**Richmond, VA 23219**	☒ **2484**	**Food**
11856	☐ **Tidewater Regional Office**	**1444 Diamond Springs Road**	**757-363-3909**	**Virginia Beach, VA 23455**	☒ **248**	**Food**

VDACS Sample No.	Inspector Code	Collected By

Collected Date and Military Time	Priority	Commodity	Related Samples
M M D D Y Y H H M M			

CATALOG NUMBERS			NAME OF TEST	No. of Units
226	-			
226	-			
	-			
	-			
Seal Intact (Yes/No)? _____			Total No. of Units	

CUSTOMER NOTES:

Identification:

Collected from a lot of:

Sample Consisted of:

Prepared in the following manner:

Delivered to: **Delivery Date:**

Establishment where collected:

Central File Number:
Distributor/Manufacturer:

Shipper: **Date of Shipment:**

Cost of samples:

Date: **Complaint Taken By:** **Complaint Referred To:**

Part I. Complainant Information

Complainant's Name:

Address:

Home Phone: **Work Phone:** **Cell Phone (if applicable):**

If necessary, best time for inspector to reach complainant . At which number? Home☐ Work☐ Cell☐

Part II. Complaint & Firm Information

Firm where product was purchased:

Address:

Product: **Date product was purchased:**

Container type (can, store wrapped package, box, etc):

Size of container: **Container code:**

Name and address of manufacturer/distributor:

Nature of complaint (please check one):

- **Filth (size, shape, color)☐**
- **Micro☐**
- **Organoleptic☐**
- **Unsanitary Conditions☐**
- **Employee Practices☐**
- **Other (specify)☐**

Description of complaint:

Does the complainant still have all or a portion of the affected food? Yes ☐ No ☐

Part III. Summary of Investigation *(to be completed by inspector)*

Date complaint was received: **Date of investigation:**

Summary:

Investigation conducted by: _____ *(signature)*

Part IV. Keying Information *(to be completed by inspector)*

CFN: **Inspection Type: State☐** **Contract☐** **Agreement☐**

New Firm☐ **Address Change☐** **Name Change☐** **Food Service☐** **HD Inspects☐**

Samples:

Classification: **Reg. Follow-up:** **Next in:** **Investigated by:**

Date: **Complaint Taken By:** **Complaint Referred To:**

Part I. Complainant Information

Complainant's Name:

Address:

Home Phone: **Work Phone:** **Cell Phone (if applicable):**

If necessary, best time for inspector to reach complainant . At which number? Home☐ Work☐ Cell☐

Part II. Complaint & Firm Information

Firm where product was purchased:

Address:

Product: **Date product was purchased:**

Container type (can, store wrapped package, box, etc):

Size of container: **Container code:**

Name and address of manufacturer/distributor:

Nature of complaint (please check one):

- **Filth (size, shape, color)☐**
- **Micro☐**
- **Organoleptic☐**
- **Unsanitary Conditions☐**
- **Employee Practices ☐**
- **Other (specify)☐**

Description of complaint:

Does the complainant still have all or a portion of the affected food? **Yes ☐** **No ☐**

Part III. Illness Questionnaire *(to be completed in instances of alleged food borne illness only)*

Date of consumption of food believed to cause illness: **Time suspected food was consumed:**

Date of onset of illness (vomiting or diarrhea): **Onset Time (best estimate):**

Which did complainant experience first (check one): **Vomit ☐** **Diarrhea ☐**

Is the complainant still experiencing vomit or diarrhea? **Yes ☐** **No ☐**

Time of last episode of vomit or diarrhea: (specify AM or PM)

Read the questions below exactly as written. Check Y for "yes", N for "no", and DK for "don't know, can't remember, not sure", etc.

Did you have?

	Y	N	DK		
Nausea	☐	☐	☐		
Vomiting	☐	☐	☐		
Diarrhea		☐	☐	☐	If yes, maximum # stools in 24-hour period:
Bloody Diarrhea	☐	☐	☐		
Abdominal Cramps	☐	☐	☐		
Fever	☐	☐	☐		
Chills	☐	☐	☐		
Headache	☐	☐	☐		
Body aches	☐	☐	☐		
Fatigue	☐	☐	☐		
Constipation	☐	☐	☐		
Burning of mouth/throat/lips	☐	☐	☐		
Metallic taste in mouth	☐	☐	☐		

Other:

Did the complainant see a healthcare professional, such as a doctor or nurse? Yes ☐ No ☐

Date seen: **Where?** **Phone #:**

Were you hospitalized overnight? Yes☐ No ☐; If so, where?

Was a stool culture done? Yes ☐ No ☐ DK ☐; If yes, what were the results?

Did anyone else in your household have a similar illness? If yes, who?

Part IV. Summary of Investigation *(to be completed by inspector)*

Date complaint was received: **Date of investigation:**

Summary:

Investigation conducted by: _____ *(signature)*

Part V. Keying Information *(to be completed by inspector)*

CFN: **Inspection Type: State☐** **Contract☐** **Agreement☐**

New Firm☐ **Address Change☐** **Name Change☐** **Food Service☐** **HD Inspects☐**

Samples:

Classification: **Reg. Follow-up:** **Next in:** **Investigated by:**