

DEPARTMENT OF FOOD AND NUTRITION



Health Department Inspection (Attach copy of Report) Pest Control Service (Attach copy of Report)		Inspection Date: Service Date:	
TO:	Mrs. Louann Glidden, Director of Operations		
FROM:		(School/Location)	
SUBJECT:	CORRECTIVE ACTION-HEALTH DEPARTMENT/PEST CONTROL		
	ment and Health Department Inspection or a ays of inspection to the Department of Food	-	
Indicate def	iciencies cited and corrective actions to be accompli	ished by food service staff.	
	Deficiency/Corrective Action	Completion Date	
Indicate def	iciencies cited and corrective actions to be accompli	ished by other departments/staff.	
	Deficiency/Corrective Action	Work Order #/Date	
Principal/De	esignee shall direct corrective action to appropriate	staff.	
		Signature of Principal/Designee	