CHESPROCOTT HEALTH DISTRICT

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Maura A. Esposito RS, MPH, Director of Health

FORM FOR PEOPLE SUBMITTING TICKS

PLEASE PRINT CLEARLY. INCLUDE FULL ADDRESS WITH ZIP CODE

DATE: _____

NAME OF SUBMITTER: _____

ADDRESS OF SUBMITTER: _____

_____

TELEPHONE: _____

E-MAIL ADDRESS: _____

NAME OF PERSON BITTEN BY TICK: _____

AGE: _____ SEX: M F

Part of body where tick was found _____

Town in which tick was acquired _____