



**Request to Accompany an Investigator**

Applicant's Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Please print)

Residence Address: \_\_\_\_\_  
Street Unit # City

Home Phone: (\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Occupation/Type of Business: \_\_\_\_\_

Please check type of facility interested in visiting and reasons for your request:

Food  Pools  Noise  Body Art \_\_\_\_\_

The Division of Public Health Inspections (PHI) allows members of the public, using their own transportation, to follow PHI investigators and accompany them on inspections conducted during the course of official city business. The Division has the right to refuse any request to participate in the program and the Division, including investigators, has the right to discontinue any individual's participation in the program for any reason. All persons applying to participate in the program must be 18 years of age or must have written approval of their legal guardian to participate. The applicant must provide legal identification with this completed form. Business casual attire is required and no photos or recordings will be permitted unless approved by the manager of the facility. If the application is approved, the Division will contact the applicant to coordinate the date, time, and location of the exercise.

**RELEASE OF LIABILITY**

I acknowledge that accompanying PHI investigators on inspections during the course of official city business involves risk and I hereby assume all risk related to and arising out of the applicant's participation in the Program. In exchange for the applicant's participation in the Program, I hereby release and waive and agree to indemnify and hold harmless the City and County of Denver, its appointed and elected officials, agents, and employees for, from, and against all claims, losses, liabilities, suits or demands for damages to persons or property arising out of, resulting from, or relating to the applicant's participation in the Program.

I have read this release, understand its contents, and by signing below, accept the terms of this release.

\_\_\_\_\_  
Print Name of Applicant

\_\_\_\_\_  
Signature of Applicant or Legal Guardian Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Director of Public Health Inspections  Approved  Denied Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*\* For Office Use Only\*\***  
Investigator Assigned: \_\_\_\_\_  
Date / Time of Visit: \_\_\_\_\_  
Comments: \_\_\_\_\_  
\_\_\_\_\_