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**Indoor Air Quality Concern Form**

This form can be filled out by the school occupant or by a member of the school staff.

|  |  |
| --- | --- |
| Name:  | Date:  |
| Department/Location in School:  | Phone:  |
| Completed by: | Title: | Phone: |

This form should be used if your concern may be related to indoor air quality. Indoor air quality problems include concerns with temperature control, ventilation, and air pollutants. Your observations can help to resolve the problem as quickly as possible. Please use the space below to describe the nature of the concern and any potential causes.

We may need to contact you to discuss your complaint. What is the best time to reach you?

So that we can respond promptly, please return this form to: Donald Race, Facilities Manager

 908-534-2859



OFFICE USE ONLY

File Number: Received by: Date Received:



**Occupant Interview Page 1 of 2**

|  |  |
| --- | --- |
| School Name:  | File Number:  |
| Address:  |
| Occupant Name: | Work Location: |
| Completed by: | Title: | Date: |

**SYMPTOM PATTERNS**

What kind of symptoms or discomfort are you experiencing?

Are you aware of other people with similar symptoms or concerns? Yes No

If so, what are their names and locations?

Do you have any health conditions that may make you particularly susceptible to environmental problems?

|  |  |  |
| --- | --- | --- |
| ❑contact lenses | ❑chronic cardiovascular disease | ❑undergoing chemotherapy or radiation therapy |
| ❑allergies | ❑chronic respiratory disease | ❑immune system suppressed by disease or |
|  | ❑chronic neurological problems | other causes |

**TIMING PATTERNS**

When did your symptoms start?

When are they generally worst?

Do they go away? If so, when?

Have you noticed any other events such as weather events, temperature or humidity changes, or activities in the school that tend to occur around the same time as your symptoms?

**Occupant Interview Page 2 of 2**

**SPATIAL PATTERNS**

Where are you when you experience symptoms or discomfort?

Where do you spend most of your time in the school?

**ADDITIONAL INFORMATION**

Do you have any observations about school conditions that might need attention or might help explain your symptoms (e.g., temperature, humidity, drafts, stagnant air, and odors)?

Have you sought medical attention for your symptoms?

Do you have any other comments?

**Occupant Diary**

|  |  |  |
| --- | --- | --- |
| Occupant Name: | Title: | Phone: |
| Location: |

On the form below, please record each occasion when you experience a symptom of ill-health or discomfort that you think may be linked to an environmental condition in this school.

It is important that you record the time and date and your location within the school as accurately as possible, because that will help to identify conditions (e.g., equipment operation) that may be associated with your problem.

Also, please try to describe the severity of your symptoms (e.g., mild, severe) and their duration (the length of time that they persist). Any other observations that you think may help in identifying the cause of the problem should be noted in the "Comments" column. Feel free to attach additional pages or use more than one line for each event if you need more room to record your observations.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Time/Date** | **Location** | **Symptom** | **Severity/Duration** | **Comments** |
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