APPENDIX 13.1-A

INDOOR ENVIRONMENTAL QUALITY CONCERN FORM

Name_____ Date_____

Command_____ Building _____

Room/Work Location_____ Phone _____

What is the best time to reach you?_____

This form should be used if your concern may be related to indoor air quality. Indoor environmental quality problems can include temperature control, ventilation, and air pollutants. Your observations are important and can help us resolve the problem as quickly as possible. Please use the space below to describe the nature of your complaint or concern, any potential causes, patterns of occurrence or other relevant information.

So that we can respond promptly, please return this form to:

_____

IEQ Manager or Contact Person

_____

Room, Building, Code, Phone

OFFICE USE ONLY

File Number_____ Received By_____ Date Received_____

Based on U.S. Environmental Protection Agency (EPA)/National Institute for Occupational Safety and Health (NIOSH). *Building Air Quality: A Guide for Building Owners and Facility Managers*. DHHS (NIOSH) Pub. No. 91-114 (EPA/400/1-91/033). Washington, DC: U.S. Government Printing Office. 1991. http://www.cdc.gov/niosh/docs/91-114/ - Indoor Air Quality Complaint Form.

APPENDIX 13.1-A

INDOOR ENVIRONMENTAL QUALITY QUESTIONNAIRE

Command_____ Building_____.
Room/Work Location_____ Date_____.

1. Do you have any complaints?
   YES_____ NO_____

   If YES, check any that apply:
   _____ temperature too cold _____ dust in the air
   _____ temperature too hot _____ disturbing noises
   _____ lack of air circulation _____ odors
   _____ other (please specify)

2. When do these problems occur?
   _____ morning
   _____ afternoon
   _____ all day
   _____ specific time(s)
   when? _____
   _____ specific day(s)
   when? _____
   _____ no noticeable trend

3. Health problems or symptoms: Describe in three words or less each problem or adverse health effect that you experience more than two times per week.

   Example: runny nose

   Symptom #1 _____

   Symptom #2 _____

   Symptom #3 _____.

   Symptom #4 _____

   Symptom #5 _____

   Symptom #6 _____

   Do the above symptoms clear up within 1 hour after leaving work? YES_____ NO_____
   If no, which symptom(s) persist throughout the week? (Circle appropriate symptom number)

   Symptom #1 #2 #3 #4 #5 #6

Do you have any health problems or allergies that might account for any of these symptoms?
YES_____ NO_____.

If yes, please describe._____.
_____.

4. Check any of the following that apply to you.
   _____ wear contact lenses
   _____ operate video display terminal at least 10% of work day
   _____ operate photocopier at least 10% of work day
   _____ operate special office machines/equipment specify type & frequency
   _____.

5. Are you taking any medication? YES____ NO____.
   If yes, what? _____.

6. Do you smoke? YES____ NO____.

7. Do others in your immediate work area smoke?
   YES____ NO____.

8. What is your job title or position? _____.
   _____.

9. Briefly describe your primary job tasks. _____.
   _____.

10. Can you offer any other comments or observations about your office environment?
   _____.
   _____.
   _____.
   _____.
   _____.

11. Your name (OPTIONAL)
   _____.

12. Your office phone number (OPTIONAL)
   _____.
   _____.

OFFICE USE ONLY

File Number_____ Received By_____ Date Received_____