
Indoor Air Quality Worksheet

Contact Sheet

Building: _____ Date: _____

Department/Location in Building: _____ Phone: _____

Completed by: _____ Department: _____ Revision 12/8/95

1. Describing Scope of the Problem: Initial Contact

Ask the following questions:

Completed

- Describe the odor and/or symptoms.

- Can you identify a possible source?

- Is anyone else complaining of the odor and/or symptoms?

- What time did the odor or complaint start.

- Is it on-going?

- Has this happened before?

- Is the odor and/or symptom occurring elsewhere in the building?

- Name and location/phone number of contact person: _____

2. Priority on answering calls:

- 2.1 Respond immediately if caller can give specific symptoms, specific odor description, high potential for chronic disease, and/or acute illness occurring. Call the Environmental Health & Safety Office at x3277 and fax the completed Contact Sheet to EHS at x2255.

- 2.2 Respond within the week if caller has only minor temporary symptoms and/or hypersensitivity responses only. Send completed Contact Sheet to the Environmental Health & Safety Office by campus mail.

- 2.3 If only vague information, nuisance dust, nuisance order, and/or curiosity, send the complainant the Investigation Form.

Indoor Air Quality Worksheet

Survey Sheet

Building: _____ Date: _____

Department/Location in Building: _____ Phone: _____

Completed by: _____ Department: _____ Revision 12/8/95

1. Describing Scope of Problem: Walk-Through Survey

Walk-through survey of the building noting the following as potential sources:

1.1 Any remodeling work?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Painting	<input type="checkbox"/>	<input type="checkbox"/>	Special cleaning projects
<input type="checkbox"/>	<input type="checkbox"/>	Plumbing	<input type="checkbox"/>	<input type="checkbox"/>	Welding
<input type="checkbox"/>	<input type="checkbox"/>	Carpet laying	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

1.2 Check Custodial closets

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Leaking containers	<input type="checkbox"/>	<input type="checkbox"/>	Moldy cleaning utensils
<input type="checkbox"/>	<input type="checkbox"/>	Leaking faucets	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

1.3 Check Sewers [dry drains, sewage visible, etc.]

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Floor drains	<input type="checkbox"/>	<input type="checkbox"/>	Toilets backing up
<input type="checkbox"/>	<input type="checkbox"/>	Sink drains	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

1.4 Fresh air intakes

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Cars idling
<input type="checkbox"/>	<input type="checkbox"/>	Trash	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

1.5 Any new activities in the building--interview occupants

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	New equipment	<input type="checkbox"/>	<input type="checkbox"/>	New space use
<input type="checkbox"/>	<input type="checkbox"/>	New furniture	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

1.7 Are there chemical spills in:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Laboratories	<input type="checkbox"/>	<input type="checkbox"/>	Offices
<input type="checkbox"/>	<input type="checkbox"/>	Closets	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

1.8 Trash cans inspected for

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Food	<input type="checkbox"/>	<input type="checkbox"/>	Cleaning chemicals
<input type="checkbox"/>	<input type="checkbox"/>	Standing liquid	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

2. Systems Evaluation

A. Review building HVAC system specifications.

Completed

1. What type of HVAC system:
- Steam Portable Electric
- Forced Air Other _____
2. Call Physical Plant for:
- System adjustments
- Filter changes and last time filters were changed. Date: _____
3. Check on smoking policy:
- Yes No
- Smoking at front doors
- Uninformed contractor/public
- No smoking policy enforced in building
4. Complete environmental screening matrix below

SAMPLING LOCATIONS

Susceptible Potential Outdoors Control Other Other
Occupants Sources Areas _____

SPECIFIC CONTAMINANTS

	Susceptible Occupants	Potential Sources	Outdoors Areas	Control Areas	Other _____	Other _____
Temperature & Humidity						
Air Exchange Rate						
Illumination						
Sound						
Carbon Dioxide						
Carbon Monoxide						
Particulate Matter						
Formaldehyde						
Nitrogen Dioxides						
Volatile Organic Compounds						
Bioaerosols						
Building Specific Compounds						
Other:						

3. Health and Comfort Assessment

- A. Ergonomic Concerns:
- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Office workstation adjusted within specified limits |
| <input type="checkbox"/> | <input type="checkbox"/> | Is chair adjustable. If yes, is it within specified limits |
| <input type="checkbox"/> | <input type="checkbox"/> | Are there other ergonomic helpers |
| | | <input type="checkbox"/> Wrist rests, Size _____ <input type="checkbox"/> Ergo keyboard |
| | | <input type="checkbox"/> Foot Rests <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> | | Number of hours per day using a computer _____ |
| <input type="checkbox"/> | | Number of hours per day at work station _____ |

4. History

- A. Building history of contaminants and complaints
- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Records of previous investigations at EHS? |
| <input type="checkbox"/> | <input type="checkbox"/> | IAQ Investigation Form completed |
| <input type="checkbox"/> | <input type="checkbox"/> | Possible work stressors: |
| | | <input type="checkbox"/> High pressure job <input type="checkbox"/> Unable to take regular breaks |
| | | <input type="checkbox"/> Long work hours <input type="checkbox"/> Overall job dissatisfaction |
| | | <input type="checkbox"/> Poor lighting <input type="checkbox"/> Personal issues |
| | | <input type="checkbox"/> Other: |

5. Closure

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | A. Proposed remedies presented to employee and supervisor/department. Explain remedies: |
| <input type="checkbox"/> | | B. Follow-up within the month, Date of follow-up: _____ |
| <input type="checkbox"/> | | C. Closure Interview: Overall response to the IAQ investigation |

Indoor Air Quality Worksheet

Investigation

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

Name: _____ Date: _____

Department/Location in Building: _____ Phone: _____

Completed by: _____ Revision 12/8/95

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

Does this building have a history of IAQ concerns that you are aware of? _____

Have you submitted an IAQ Investigation Form with the EHS office before? _____ If yes, when? _____

So that we can respond promptly, please return this form to: **Indoor Air Quality Investigation Team
Environmental Health & Safety
Merica Hall, Room 312, CAMPUS**

This form should be used if your concerns may be related to indoor air quality. Indoor air quality problems include concerns about 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 complaint and any potential causes.

Please turn form over to continue your responses.

SYMPTOM PATTERNS

What kind of symptoms or discomfort are your experiencing?

Do you have any of the following health conditions?

- Contact lenses Chronic cardiovascular disease Undergoing chemotherapy or radiation therapy
- Allergies Chronic respiratory disease Immune system suppressed by disease or other causes
- Back Pain Carpal Tunnel Syndrome Smoker Multiple Chemical Sensitivity

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 building) that tend to occur around the same time as your symptoms?

SPATIAL PATTERNS

Where are you when you experience symptoms or discomfort?

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

ADDITIONAL INFORMATION

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

Are you aware of other people with similar symptoms or concerns? Yes_____No_____

If so, what are their names and locations?_____

EHS OFFICE USE ONLY

File Number: _____ Received by: _____ Date Received: _____

- Microbial Sources HVAC Ergonomics Outdoor Environmental Tobacco Smoke
- Chemical Usage/ Storage Other _____

Indoor Air Quality Worksheet

Closure Interview

Building: _____ Date: _____

Department/Location in Building: _____ Phone: _____

Completed by: _____ Department: Environmental Health & Safety Revision 12/8/95

1. CLOSURE INTERVIEW, Ask the following questions:

1.1 Initial Contact By Employee

Yes No
 a. Did you contact this office by phone? If yes, who did you speak with _____

c. Was that person helpful? If no, what could have been done better?

1.2 Walk-thru Survey

a. Who responded _____

Yes	No			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	Was the response timely	Was that person helpful	<input type="checkbox"/>	<input type="checkbox"/>

4. Did you provide assistance in the investigation? If yes, how much

1.3 Addressing the Problem

Yes	No			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	Did you enact the solution we proposed	Are you more productive	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Have the symptoms gone away	Was the problem solved	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Have others in your work area received benefits? If so, how? _____			

1.4 Concerns

Do you have any other health and/or safety concerns?
 Would you feel comfortable calling us again?
a. If no, why? _____

RECORDKEEPING

- Completed
- A. Final letter sent to close investigation.
 - B. All checklists, questionnaires, copies of memo's and letters kept in building IAQ file.
 - C. IAQ action file crossed referenced by person