

Goshen College

Indoor Air Quality Complaint Form

Person reporting the problem _____

Phone _____

Building _____

Date _____

Area with complaints _____

No. occupants with problem _____

Number of Occupants in area _____

Percent of people with problem _____

PROBLEM DESCRIPTION (Completed by person reporting the problem)

When did the problem first occur? Time of day _____ Day of week _____

Symptoms described by occupants

Operations, conditions, or modifications that may have contributed to the problem:

<input type="checkbox"/> Water Damage	<input type="checkbox"/> Remodeling	<input type="checkbox"/> Stuffy Air	<input type="checkbox"/> Pesticide Spraying
<input type="checkbox"/> Odors	<input type="checkbox"/> Carpet, age/moldy	<input type="checkbox"/> Painting	<input type="checkbox"/> Equipment Cleaning
<input type="checkbox"/> Furniture, age/moldy	<input type="checkbox"/> Dry drain traps	<input type="checkbox"/> Air intake	<input type="checkbox"/> New material
<input type="checkbox"/> Repeat Problem	<input type="checkbox"/> Temp problem	<input type="checkbox"/> Visible Mold	<input type="checkbox"/> Other

Comments:

