

# Indoor Air Quality Concern Form

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

Date:	Occupant/Staff Name:
Room Number:	Building:

Please describe what you think the indoor air quality concern relates to:

Please describe any specific physical symptoms you may be experiencing:

Please describe the weather conditions and note the time of the day:

Please estimate the number of building occupants that are located in the area of concern:

Please note any other additional observations you would like to make:

Please return this completed form to the Director of Facility Services.

Department Use Only: Date Received \_\_\_\_\_  
Date Responded \_\_\_\_\_  
Date Investigated \_\_\_\_\_