



Indoor Air Quality Problem Reporting Form

HS9

IDENTIFICATION

School: _____ Date: _____
 Name: _____ Employee Number: _____
 Occupation: _____ Work Area (room number): _____

WAS THE PRINCIPAL NOTIFIED OF THE SITUATION? No Yes When: _____

DESCRIPTION OF THE PROBLEM

Symptoms or discomfort experienced	_____ _____
Specific time of the day the symptoms are experienced: <input type="checkbox"/> am <input type="checkbox"/> pm	How many hours were you at work before symptoms appeared? _____
Frequency and duration of symptoms: When do the symptoms usually subside?	_____ _____
History of symptoms · When were they first noticed? · Have you seen a doctor for these symptoms? No <input type="checkbox"/> Yes <input type="checkbox"/>	Date: _____ If yes, when: _____
Building conditions or work activities that may be related to IAQ problems (renovation, new equipment, etc.)	_____ _____

Comments:

Worker's signature: _____ Date: _____
year/month/day

I declare that I have taken notice of the present document.

Signature: _____ Position: _____ Date: _____
Immediate supervisor or replacement year/month/day

Completed forms must be sent to Human Resources Dept. c/o Health and Safety Office