University of the Incarnate Word
Environmental Health Safety and Risk Management
Indoor Air Quality Assessment

**General Data**

Occupant Name: _____ Date: _____

Building: _____ Room Number: _____ Phone Number: _____

Department: _____ Supervisor's Name: _____

**Indicate the symptoms experienced by the occupant**

| | | |
|---|---|---|
| Coughing ◯ | Back Aches ◯ | Nausea ◯ |
| Dry/itchy Eyes ◯ | Sore Throat ◯ | Congestion ◯ |
| Headaches ◯ | Runny nose ◯ | Ear Aches ◯ |
| Drowsiness ◯ | Dry skin ◯ | Other_____ |

- Indicate the approximate time of day that symptoms begin: _____
- Indicate the approximate time of day that symptoms end or improve: _____
- Do symptoms end or improve on the weekends or during vacations: _____
- Is your office /area generally warmer than you find comfortable? Y/N
- Is your office/area generally cooler than you find comfortable?
- Do you have any known allergies? Y/N
  - Please list:_____
- Are there any known sources of these allergies in your work area?
  _____

Certification: I certify that the information provided is correct to the best of my knowledge. I understand that the person completing this evaluation is not a qualified medical professional. Further, the noted symptoms may be a sign of a serious medical condition which should be evaluated by a qualified medical professional.

***Signature:*** **_____** ***Date:*** **_____**

**Indoor assessment Data** *(***To be completed by EHSRM staff only if necessary***)*

Indoor Temperature: _____ F Indoor Relative Humidity: _____%

Indoor CO2: _____PPM

***Room condition***

| | Yes | No | N/A | Comments |
|---|---|---|---|---|
| Is smoking allowed? | | | | |
| Housekeeping adequate? | | | | |
| Ceiling tiles in place? | | | | |

| | Yes | No | N/A | Comments |
|---|---|---|---|---|
| Any sources of VOCs? | | | | |
| Any Standing Water in room? | | | | |
| Heavy fabrics/ carpets? | | | | |
| Potted Plants? | | | | |
| New carpet installed | | | | |
| New furnishings | | | | |
| Constructions dust present? | | | | |
| Damaged or wet ceiling tiles? | | | | |

***Air Hander Information***

| | Yes | No | N/A | Comments |
|---|---|---|---|---|
| Air Handler Location:_____ | | | | |
| Air Handler Number:_____ | | | | |
| Air handling room free of debris? | | | | |
| Air handling room free of water? | | | | |
| Date of previous air handler cleaning | | | | |
| Date of last Duct Cleaning: | | | | |

**Room Information**

| | Yes | No | N/A | Comments |
|---|---|---|---|---|
| Number of air changes per hour: | | | | |
| Signs of previous water damage: | | | | |
| Evaluate location of exhaust and supply | | | | |
| Air pressure with respect to corridor: | | | | |
| Temperature concerns by occupants? | | | | |
| Date of last terminal duct cleaning: | | | | |