



GUSTAVUS ADOLPHUS COLLEGE

ENVIRONMENTAL HEALTH, SAFETY & RISK MANAGEMENT OFFICE

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INDOOR AIR QUALITY SURVEY

1. Do you frequently have any of the following concerns regarding the indoor air quality at this building? (Please check all that apply)

- Temperature too cold Temperature too hot Dusty Noisy Stuffy air Too dry
 Moldy odors Too humid Other odors (please describe) Drafty Crowded work area
 Poor lighting Vibration Other _____ No complaints

2. Do any of the following apply to you? (Please check all that apply)

- Wear contact lenses Operate computer monitors at least one hour/average day
 Operate photo copiers for more than one hour/average day
 Use any new shampoos, new colognes, new laundry detergent, new antiperspirants
 Use any chemical substances such as cleaners, hair spray, laundry sprays, magic markers, white out, etc.
 Use carbonless copy paper Use tobacco products None of the above

3. During the last year while being in the building, have you experienced any of the following symptoms? (Please check all that apply)

- Frequent cough Nasal congestion Wheezing (except colds) Sinus infections
 Multiple colds Sore throat Shortness of breath Hoarse voice Migraines Headaches Eye irritation Sneezing attacks Other (please specify) _____
 None of the above

4. Have you received medical treatment for any of the above?

- Yes No

5. How would you rate the indoor air quality at this building?

- Good Average Poor

6. If you feel that there is an indoor air quality problem, does the problem occur more frequently during specific seasons of the year?

- Yes No Don't know Not applicable
 Winter(Dec.-Feb.) Spring (March-May) Summer (June-Aug.) Fall(Sept.-Nov.)

If yes, when do indoor air problems seem to be most notable?

- Morning Mid-day Afternoon
Specific Days (Mon Tu Wed Th Fri Sat Sun)
 All day Not applicable

7. Do most of the symptoms checked above go away within 1 hour after leaving the building?

- Yes No Not applicable

If no, do they go away by the next morning?

- Yes No Not applicable

8. Please rank your building as to health and safety conditions.

- Excellent Good Average Poor Bad

9. What percentage of your typical day do you spend in your building?

- 0%-25% 26%-50% 51%-75% 76%-100%

10. Are any of the following items located within your room or work area? (check all that apply)

Photo copier Laser printer Windows Plants Trash receptacles

11. How much control do you have over the air quality in your room or work environment?
(temperature, air, movement, etc.)

Very good control Some control No control

12. Which of the following can you individually control?

Temperature Air movement Light intensity No control

13. Please rate the lighting at your facility.

Too bright Just right Too dim

14. Has there been any renovation/demolition related activities occurring in or near your room or work area? (Ex. new carpet, painting, new furniture, HVAC work, etc.) If so, please specify below:

15. Has there been any evidence of water leaks or visible signs of moisture in and around your room or work area?

Yes No

If yes, please describe (include location & duration)

16. Is your room or work area near or in a laboratory that uses chemicals?

Yes No

If yes, list the substances known to be used.

17. Are there others in the building who may have similar concerns? Yes No

Please provide their names and locations _____

Your Name (optional) _____

Telephone # (optional) _____

Job Title/Position _____

Name of Building: _____ Room #: _____

Date: _____

Please return completed forms to:

DALE PLEMMONS
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