

LINDENWOLD PUBLIC SCHOOLS
FACILITIES DEPARTMENT

INDOOR AIR QUALITY (IAQ) OCCUPANT INTERVIEW

Building: _____ R/O Number: _____

Occupant Name: _____ Work Location: _____

Completed by: _____ Title: _____ Date: _____

Symptoms/Patterns:

What type of symptoms or discomfort are you experiencing?

Are you aware of other people with similar symptoms or concerns? Yes _____ No _____

If yes, what are their names and locations?

_____	_____
_____	_____
_____	_____

Timing Patterns:

When did your symptoms start?

When are they generally worse?

Do they go away? If so, when?

Have you noticed any other events (such as weather events, temperature or humidity changes, or activities in the building) that tend to occur around the same time as your symptoms?

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Spatial Patterns:

Where are you when you experience symptoms or discomfort?

Where do you spend most of your time in the building?

Additional Information:

Do you have any observations about building conditions that might need attention or might help explain your symptoms (e.g., temperature, humidity, drafts, stagnant air, odors)?

Have you sought medical attention for your symptoms?

Do you have any other comments?