

RADON IN AIR RADON IN AIR SAMPLE DATA FORM

Send Written Report to:

Name: _____
Address _____
City /State/Zip _____
Phone #: _____
Email: _____

Property Tested:

Owner: _____
Address: _____
City/State/Zip: _____
County _____

Test Location Data:

Check here if there is an operating radon system in this house.

1ST DEVICE NUMBER _____	LOCATION: <input type="checkbox"/> Basement <input type="checkbox"/> First Floor <input type="checkbox"/> Other Floor _____ <input type="checkbox"/> Room _____ Location in Room _____
2ND DEVICE NUMBER _____	LOCATION: <input type="checkbox"/> Basement <input type="checkbox"/> First Floor <input type="checkbox"/> Other Floor _____ <input type="checkbox"/> Room _____ Location in Room _____

Check here if devices were place side by side, four inches apart

Were foundation vents or any other permanent vents open? Yes No
Were test devices placed and retrieved by the same person? Yes No
Test Purpose? Initial Test Follow Up Post Mitigation Real Estate
Structure Type: Basement Crawl Space Slab on Grade Other _____
(check all that apply)

INDOOR CONDITIONS (NOTE: Extreme conditions will invalidate test.)

Were closed house conditions maintained? Yes No
Temperature: Normal Actual _____ **Humidity:** Normal Actual _____

OUTDOOR CONDITIONS

Precipitation Present: Yes No If Yes, Severe? Yes No
Wind Present: Yes No If Yes, Severe? Yes No

EXPOSURE PERIOD

Beginning Date: ____/____/____ Time: _____ AM/PM
Ending Date: ____/____/____ Time: _____ AM/PM

The test device must remain open for 48 to 96 hours.
Return this **COMPLETED FORM** with the device to the laboratory.
PLEASE NOTE: LAB MUST RECEIVE SAMPLE WITHIN 30 HOURS OF WHEN SAMPLE IS TAKEN

*****LAB USE ONLY*****

DATE/TIME REC'D IN LAB: _____ LAB PROJECT #: _____ DUE DATE: _____ RUSH? _____	PAID BY: Check #: _____ C/C: _____ OTHER: _____ AMT. PD: _____ DATE PD: _____ REC'D BY: _____
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