

Name (optional): _____
 (without a name attached to this form it is much more difficult to address the issue, please consider putting your name on the form.)

CTA Indoor Air Quality Employee Report

1. Please check the nature of the complaint

- Temperature too cold
- Temperature too hot
- Lack of circulation (stuffy)
- Noticeable odors
- Dust in the air
- Dust, dirt or debris layer covering room
- Disturbing noises
- Other, please specify _____

2. When do these problems occur?

- Morning
- Afternoon
- Night
- All day, every day
- No noticeable pattern
- Daily
- Specific day(s) of the week, please specify _____

3. Are there health problems or symptoms?

Describe in three words or less each symptom or adverse health effect you experience more than two times per week. Please check the appropriate columns related to each symptom.

Example: *Runny nose*

Symptom	Clears up within hour after leaving work (yes or no)	Symptom last throughout the week but dissipates over weekends or breaks from work (yes or no)	Do you have a health problem or allergies that may account for the symptom? (yes or no)	Comments

Name (optional): _____
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4. Do any of the following apply to you?

- Wear contact lenses
- Operate video display terminals at least 10% of your day
- Operate photocopier machines at least 10% of your day
- Use or operate other machinery or special supplies, please specify _____

5. What building are you in and the room number(s)?

Building _____

Room # _____

6. What is your job title? _____

7. Can you offer any comments or observations concerning the issue?