



Bureau of Community Environmental Health  
Radon and Indoor Air Quality



**Mandatory Measurements**  
**NONRESIDENTIAL RADON MEASUREMENT REPORT**

FOR BUILDINGS OTHER THAN SINGLE OR MULTI FAMILY DWELLING

Page \_\_\_ of \_\_\_

**SECTION 1: FACILITY AND OWNER INFORMATION**

Facility Information:

Facility Name (as licensed, registered, or listed with state)

Physical location (Street Address) of Facility Site

City County Zip

Name of Contact Person

Title Phone Number

Owner Information:

Name of Owner

Street Address

City State Zip

( )

Phone Number

Facility type as licensed or registered (check all that apply):

- Assisted Living Facility (previously ACLF)
- Alcohol, Drug Abuse or Mental Health
- Correctional Facility or Jail
- Day Care Center (pre kindergarden)
- Delinquency Program (Ex: Start Center, Training School)
- OTHER (specify) \_\_\_\_\_
- Hospitals (Acute Care, Physical Rehab., Psychiatric, or Intensive Residential Treatment)
- Nursing Home/Skilled Nursing Facility
- Public School (K-12)
- Private School (K-12)

**SECTION 2: BUILDING INFORMATION**

One form must be completed for each building tested.

Building Name or ID Number (If Applicable)

Street Address of Building (If Different From Facility Site)

Buildings per address \_\_\_; Building No. \_\_\_ of \_\_\_ requiring testing.

\_\_\_ No. of Stories, \_\_\_ No. of Stories Occupied, \_\_\_ Year Built

CHECK ALL THAT APPLY

Foundation/Floor

- System:
- Slab
  - Crawlspace
  - Pier
  - Floored Basement
  - Bare Earth Basement
  - Other(specify) \_\_\_\_\_

HVAC System:

- HVAC:
- (system with fresh air intake)
- Single Zone / single return
  - Multiple Zones / multiple returns
  - Multi-Story Zones - one system for more than one floor

Nonventilating HAC:

- (system without fresh air intake)
- Central Ducted A/C
  - Central Ducted Heat
  - Space Heater

Other HVAC:

- Window/Wall Unit
- No A/C
- No Heat
- Other (specify) \_\_\_\_\_

Building Features:

- Elevator(s)
- Internal Stairs
- Mechanical Chases
- Suspended Ceilings
- Exhaust Fans

**For Official Use Only:**

Date Received	Reviewed By	Entered By

**SECTION 3: RESULTS**

**Room Testing Requirements:**

For facilities opened since July 1<sup>st</sup>, 1999, two sets of tests are required. Initially a minimum of 20% of the ground contact rooms used by your clients shall be tested. Examples: bedrooms, classrooms, dayrooms, cafeteria, public offices. Rooms that clients are not allowed access to or rooms not designated for long term occupancy are not included in the radon testing. Examples: bathrooms, kitchens, storage rooms, employee lounge, secure file rooms, private offices. After five years, retest a minimum of 5% of the same rooms. You are then finished testing unless you change your facility licensing, become legally new or modify a building's structure.

For facilities opened prior to July 1<sup>st</sup>, 1999 and operated continuously with out radon testing, call the Radon and Indoor Air Toxics programs at 800-543-8279, to determine your testing requirements.

Measurement Type:  Initial or  5 Year Retest

Dates of Measurement: FROM      /      /      TO      /      /

Name of Person who performed Measurement (Placed Device)				Certificate No. (If Applicable)	
<u>Story</u>	<u>Room</u>	<u>Result</u>	<u>Units<sup>†</sup></u>	<u>Device<sup>‡</sup></u>	<u>Time in Hours</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

<sup>†</sup> P for pCi/L or W for WL

<sup>‡</sup> AC-Activated Carbon Adsorption, AT-Alpha Track, CR-Continuous Radon Monitor, CW-Continuous Working Level Monitor, EL-Electret Ion Chamber Long Term, ES-Electret Ion Chamber Short Term, LS-Liquid Scintillation, RP-RPISU, UT-Unfiltered Alpha Track

**SECTION 4**

COMPLETE ONLY IF MEASUREMENTS ARE PERFORMED BY A RADON MEASUREMENT BUSINESS

Name of Business and Cert. No. \_\_\_\_\_ Name of Specialist and Cert. No. \_\_\_\_\_ Signature of Specialist \_\_\_\_\_

**SECTION 5**

I hereby certify that the Radon measurements reported herein have been performed in accordance with Chapter 64E-5, Florida Administrative Code, and Chapter 404, Florida Statutes.

Authorized Representative of Facility \_\_\_\_\_ Date \_\_\_\_\_

Upon completion of this form, send to :  
 Department of Health  
 Bureau of Community Environmental Health / Radon and Indoor Air Quality  
 4052 Bald Cypress Way, Bin #A08  
 Tallahassee, FL 32399-1710

For Assistance in Completing this Form call 1-800-543-8279