SECTION 1: FACILITY AND OWNER INFORMATION

Facility Information:

Name of Facility (as licensed or registered)

Physical location (Street Address) of Facility Site

City          County          Zip

Name of Contact Person

Title

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

☐ Assisted Living Facility (previously ACLF)
☐ Alcohol, Drug Abuse or Mental Health
☐ Developmentally Disabled (Ex: ICFDD Cluster, Small Group Homes)

☐ OTHER (specify)

Owner Information:

Name of Owner

Street Address

City          State          Zip

(____)  Phone Number

SECTION 2: BUILDING INFORMATION

Check All That Apply

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, _____ Age of Building in Years (or year built)

Number of measurements required in this building during this testing period: _____ initial short term, _____ follow-up

Cummulative number of measurements reported for this testing period: _____ initial short term, _____ follow-up

Upon completion of this form, send to:

Department of Health
Bureau of Environmental Health / Radon Program
4052 Bald Cypress Way, Bin #A12
Tallahassee, FL 32399-1720

You may scan the report and email it to RadonReports@FLhealth.gov

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

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SECTION 2: BUILDING INFORMATION CONTINUED

Foundation/Floor System:
- Slab
- Crawlspace
- Pier
- Basement
- Other (specify) ___________________

Cooling System:
- Central A/C,
- Room A/C,
- Window Fans,
- Attic Fan \(\text{(Whole House Fan)}\),
- Other (specify): ___________________

Heating System:
- Central (ducted) Heat:
  - Combustion \(\text{(gas, oil, etc.)}\)
  - Non-Combustion \(\text{(electric)}\)
- Space Heat:
  - Combustion \(\text{(gas, oil, etc.)}\)
  - Nonvented \(\text{(room kerosene)}\)
  - Vented \(\text{(woodstove, etc.)}\)
  - Fireplace
  - Non-Combustion \(\text{(electric, Radiant)}\)
  - Other (specify): ___________________

___ In Use During Measurement \(\text{(Y/N)}\)?

SECTION 3: RESULTS

Measurement type:
- Initial short term,
- Short term follow-up,
- Long term follow-up

Dates of Measurement: FROM / / TO / /

Name of Person who performed Measurement (Placed Device) ___________________
Certificate No. (If Applicable) ___________________

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<thead>
<tr>
<th>Story</th>
<th>Room</th>
<th>Result</th>
<th>Units †</th>
<th>Device‡</th>
<th>Time in Hours</th>
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† P for pCi/L or W for WL
‡ 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

TO BE COMPLETED BY A RADON MEASUREMENT BUSINESS IF THEY PERFORMED THE MEASUREMENTS

Name of Business and Cert. No. ___________________ Name of Specialist and Cert. No. ___________________

Signature of Specialist ___________________

SECTION 5

COMPLETE ONLY IF MEASUREMENTS ARE PERFORMED BY STAFF EMPLOYED BY THE FACILITY

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 ___________________