Bureau of Environmental Health
Radon Program

Mandatory Measurements

NONRESIDENTIAL RADON MEASUREMENT REPORT

FOR BUILDINGS OTHER THAN SINGLE OR MULTI FAMILY DWELLING

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 (Submit individual facilities separate. I.E. A Day Care and School at the same place):

- ☐ 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

Building Name or ID Number (If Applicable)

Street Address of Building (If Different From Facility Site)

Buildings per address ___; Building No. ___ of ___ requiring testing.

Number of measurements required in this building during this testing period: _____ initial or 5 year retest, _____ follow-up
Cumulative number of measurements reported for this testing period: _____ initial or 5 year retest, _____ follow-up

____ No. of Stories, ____ No. of Stories Occupied, _____ Age of Building in Years (or year built)

CHECK ALL THAT APPLY

Foundation/Floor System:

- ☐ Slab
- ☐ Crawlspace
- ☐ Pier
- ☐ Floored Basement
- ☐ Bare Earth Basement
- ☐ Other (specify) _____

Year Built ____
No. of Stories ____
No. Stories occupied __

SECTION 3: RESULTS

Measurement Type: ☐ Initial or 5 Year Retest, ☐ Follow-up

Dates of Measurement: FROM ____/____/____ TO ____/____/____

Name of Person who performed Measurement (Placed Device) _____

Certificate No. (If Applicable) _____

Story	Room	Result	Units†	Device‡	Time in Hours

† 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

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

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 _____

Upon completion of this form, **send to**:
Department of Health
Bureau of Environmental Health / Radon Program
4052 Bald Cypress Way, Bin #A08
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