Compressed Air Form  s. 381.895, F.S.
Chapter 64E-20, F.A.C.

Please complete all sections:

Name of Company: _______________________________________________________

Street Address: __________________________________________ FL, City: ____________

Zip: _______________ County: _______________ Telephone: (______)_______________

Fax: (_____)____________________ E-Mail: ____________________________________

Owner’s Name: ___________________________________________________________

Mailing Address: __________________________ City: ___________ State___ Zip: _______

Telephone: (_____)__________________ Fax: (_____)__________________

E-Mail: _____________________________________________

Current Air Quality Testing Company Used: _________________________________

Address: __________________________ City: ___________ State___ Zip: _______

Telephone: (_____)__________________ Fax: (_____)__________________

Please Indicate Your Current Quarterly Testing Schedule:

☐ Jan/Apr/Jul/Oct
☐ Feb/May/Aug/Nov
☐ Mar/Jun/Sep/Dec

If testing is not currently being performed, your quarterly schedule will begin with the month following submission of this form.

Shops not open year round only need to submit results for the quarters they are open.

Is Shop Open Year Round?  Yes _____  No _____  If no, indicate below the months it is open:

Jan __ Feb __ Mar __ Apr __ May __ June __ July __ Aug __ Sept __ Oct __ Nov __ Dec __

This form is for your convenience in reporting information required in s. 381.895., F.S. Completed form and all sample results should be sent to: Bureau of Epidemiology, 4052 Bald Cypress Way, Bin A12, Tallahassee, Florida, 32399-1720. For your convenience, this form is also available to you on line at: www.floridahealth.gov under Healthy Environments - Recreational Diving.

DH 4125, 1/00