



Bureau of Environmental Health
Radon Program



Monthly Report
for Certified Radon Businesses
RADON MITIGATION REPORT

Month of _____, 20__

Page ___ of ___

Name of Business and Cert. No.

Name of Specialist and Cert. No.

Specialist's Initials

SECTION 1

Date mitigation Completed

Buildings per address _____ Building No. ___ of ___ mitigated

Street Address of Building (physical location)

City

County

Zip

Classification of Building:

- Single Family Residence Complete Sections 2,4,5
- Multiple Family Residence

- School
- Child Care Center
- 24 Hour Care Facility Complete Sections 3,4,5
- Nonresidential (specify):

SECTION 2

Check All That Apply

Type of Building:

Unattached:

- Mobile Home,
- Single Level,
- Multi Level

Attached:

- Row House (Town House,
Duplex, Side by Side living units)
 - Single Level,
 - Multi Level
- Apartment (Condominium,
over/under living units)
- Other (specify):

Cooling System:

- Central A/C,
- Room A/C,
- Window Fans,
- Attic Fan (Whole House Fan),
- Other (specify):

Heating System:

Central (ducted) Heat:

- Combustion(gas, oil, etc.)
- Non-Combustion(electric)

Space Heat:

- Combustion(gas, oil, kerosene etc.)
- Non-Combustion(electric,
Radiant)
- Other (specify):

Foundation/Floor System:

- Slab
- Crawlspace
- Pier
- Basement
- Other (specify):

No. of Stories,

Age of Building
in Years

SECTION 3
Check All That Apply

Foundation/Floor Type

- Slab
- Crawlspace
- Basement
- Bare Earth Cellar
- Pier/Pillar
- Other (specify): _____

_____ No. of Stories

HVAC System

- HVAC:
- Single Zone
 - Multiple Zones
 - Multi-Story Zones
- Nonventilating HAC:
- Central Ducted A/C
 - Central Ducted Heat
 - Space Heat
- Other:
- Window/Wall Unit
 - No A/C
 - No Heat
 - Other (specify): _____

Building Features

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

_____ Age of Building
(in Years)

SECTION 4

PRE-MITIGATION TEST:

POST-MITIGATION TEST:

Business That
Performed Measurement

Person That
Performed Measurement

Name and Cert. No.

Name and Cert. No.

Name and Cert. No.

Name and Cert. No.

Story	Apt/Room
_____	_____
_____	_____
_____	_____

From	To	Result†	Device‡	Total Hrs
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____

From	To	Result†	Device‡	Total Hrs
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____
___/___/___	___/___/___	_____	_____	_____

†in pCi/L or WL (P or W); ‡AC-Activated Carbon Adsorption, AT-Alpha Track, CR-Continuous Radon Monitor, CW-Continuous Working Level Monitor, ES-Electret Ion Chamber-Short Term, EL-Electret Ion Chamber-Long Term, LS - Liquid Scintillation

SECTION 5
Check All That Apply

TYPE OF MITIGATION SYSTEM INSTALLED

- Sub Slab Depressurization
- Mechanical Ventilation
- Crawl Space Depressurization
- Sealing Slab Cracks and Openings
- Other (Specify) _____
- Block Wall Depressurization
- Mechanical Heat Recovery Ventilation
- Crawl Space Ventilation

Describe Special Features _____

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