



A Union of Professionals

# WORK SHOULDN'T HURT

## Indoor Air Quality Survey

The union is conducting this survey to determine the existence, extent, and possible causes of indoor air quality problems at your facility. Please take a few minutes and complete it. All responses are anonymous.

1. Do you currently have any illnesses, symptoms or discomfort that you attribute to conditions in your room or building? Yes \_\_\_\_\_ No \_\_\_\_\_
2. How is your general comfort at work? Please identify any complaints that apply to you and describe their frequency below.

	Frequency of Occurrence		
	Never	Once a week or less	More than once a week
Room is too hot?			
Room is too cold?			
Stuffy air?			
Air is too moist?			
Air is too dry?			
Air is too dusty?			
Noticeable odors?			

3. How is your health at work? Please indicate which of the following symptoms you experience at work, as well as the frequency of their occurrence?

	Frequency of Occurrence		
	Never	Once a week or less	More than once a week
Dry skin/skin irritation?			
Eye irritation?			
Contact lens discomfort?			
Headache?			
Fatigue?			
Drowsiness?			
Sinus congestion/infection?			
Throat irritation?			

The American Federation of Teachers is a union of 1.7 million professionals that champions fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. We are committed to advancing these principles through community engagement, organizing, collective bargaining and political activism, and especially through the work our members do.

Randi Weingarten  
PRESIDENT

Fedrick C. Ingram  
SECRETARY-TREASURER

Evelyn DeJesus  
EXECUTIVE VICE PRESIDENT



	Frequency of Occurrence		
	Never	Once a week or less	More than once a week
Runny nose?			
Chest tightness/wheezing?			
Allergies?			
Difficulty breathing?			
Recurrent fever?			
Nausea?			
Muscle weakness?			
Loss of coordination?			
Heart palpitation?			

4. Do any of your symptoms occur more frequently at certain times of day? Yes No

If so, when? (Check all that apply)

	Yes	No
Morning		
Midday		
Afternoon		

5. If you have health symptoms while in this building, how long do they last after you have left the building?

	Yes	No
Less than one hour		
1-12 hours		
Overnight		
Over the weekend		
Longer than two days		

6. Have you been diagnosed by a healthcare provider with any of the following since beginning work at your present facility? (Check all that apply)

	Yes	Dates	No
Asthma			
Chronic bronchitis			
Chronic sinusitis or sinus infection			
Sarcoidosis			

Allergies			
Other illness you associate with your workplace			

7. Does your room have any visible mold growth?            Yes    No

If so, where in the room is the mold growing?

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8. Is there evidence of water leaks in your room? (i.e., water stains on tile, walls, or carpet)    Yes    No

If so, where in the room are the water leaks?

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9. Has there been any renovation work in your room or facility over the last year? (carpet replacement, painting, window replacement, etc.)    Yes    No

If so, please describe

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10. Please describe any other conditions/problems that may be contributing to your discomfort and/or symptoms

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11. Work location \_\_\_\_\_

12. Job classification \_\_\_\_\_

**13. How many years have you worked at your current location?**

Less than one year _____
1-5 years _____
6-10 years _____
11-15 years _____
16-20 years _____
More than 20 years _____

**14. Age?**

Under 20 _____
20-25 _____
26-30 _____
31-35 _____
36-40 _____
41-50 _____
51-55 _____
55-60 _____
Over 60 _____

**16. Sex**

Male _____
Female _____
Prefer not to answer _____