NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Environmental Radiation Protection
547 River Street, Room 530
Troy, NY 12180-2216

Radon Testing Report

Name: _____

Firm Name: _____ Year: _____

Street Address: _____ Period: ☐ January-June ☐ July-December
(report due 30 days following end of the semi-annual period)

City: _____

State: _____ Zip Code: _____

Email: _____ Phone #_____

If you utilize an external laboratory to complete your radon in air analysis, please indicate the name of the laboratory or Environmental Laboratory Approval Program (ELAP) identification number where radon in air analysis is completed, ***even if they report for you:*** _____
_____

Does your firm utilize a continuous radon monitor, electrets, or a working level monitor? ☐ Yes ☐ No

Are the results analyzed by your firm? ☐ Yes ☐ No Model Name: _____

Zip Code (Required)	**Town**	**County** (Alternative Required)	**Test Date**	**Number of Measurements** (Required)	**Measurement Activity** (pCi/L)	**Measurement Location** (i.e. basement, 1st Floor)

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