Rhode Island Department of Health
Center for Healthy Homes and Environment—Radon Control Program

3 Capitol Hill, Room 206
Providence, Rhode Island 02908

Radon Test Results for Non-Residential Buildings

Report for quarter ending (check one): ◯ March 31 ◯ June 30 ◯ September 30 ◯ December 31

Year: _____

Radon Testing Business Information

Business Name: _____ RIDOH License No.: _____

Street Address: _____ City/State/ZIP: _____

Email: _____ Phone: _____

Radon Test Results

Radon test results must be reported on the following pages and include the below information. Include as many pages as necessary to report all results. Total number of pages: _____

- Facility Type
- Facility/Building Name, as applicable
- Facility Address
- Radon Inspector Name and RIDOH License No.
- Radon Analytical Service Name and RIDOH License No.
- Test Type (Initial, Follow up, 3-year Retest, Post-Mitigation)
- Test Start Date and End Date
- Test Location (floor, room/area)
- Test Method/Device (see key)
- Test Result (pCi/L or WL)

Certification

I hereby certify that all radon test results attached hereto were performed in accordance with the *Rules and Regulations for Radon Control* (216-RICR-50-15-2) and that all information contained herein, including any supplements attached hereto, are true and correct to the best of my knowledge and beliefs.

I hereby certify that no radon tests were performed during the reporting quarter.

_____

Print Name Title RIDOH License No.

_____

Signature Date

_____

Email Phone

Submit completed report to: **Email: doh.radon@health.ri.gov**
Fax: 401-222-2456 or 401-222-2579

Questions can be directed to the Radon Program at doh.radon@health.ri.gov or 401-222-7796.

Facility Type (check one):

◯ Public Building ◯ Child Care Center ◯ Home

◯ School (pre-K – 12) ◯ Family Daycare ◯ Other

Facility Name:_____ Building Name:_____

Street:_____ City/State/ZIP:_____

Inspector Name:_____ RIDOH License No.: _____

Analytical Service Name:_____ RIDOH License No.: _____

Test type (check one.): ◯ Initial ◯ Follow up ◯ 3-year Retest ◯ Post-Mitigation

Test Start Date	**Test End Date**	**Floor**	**Room/Area**	**Method/Device** (see key)	**Result** (pCi/L or WL)

Facility Type (check one):

◯ Public Building ◯ Child Care Center ◯ Home

◯ School (pre-K – 12) ◯ Family Daycare ◯ Other

Facility Name:_____ Building Name:_____

Street:_____ City/State/ZIP:_____

Inspector Name:_____ RIDOH License No.: _____

Analytical Service Name:_____ RIDOH License No.: _____

Test type (check one.): ◯ Initial ◯ Follow up ◯ 3-year Retest ◯ Post-Mitigation

Test Start Date	**Test End Date**	**Floor**	**Room/Area**	**Method/Device** (see key)	**Result** (pCi/L or WL)

KEY	**ATD**	**CA**	**CLS**	**CRM**	**EIC**	**RPISU**	**WLM**	**RW**
Testing Method/ Device	Alpha Track Detector	Charcoal Adsorption Device	Charcoal Liquid Scintillation Device	Continuous Radon Monitor	Electret Ion Chamber	Radon Progeny Integrating Sampling Unit	Working Level Monitor	Water

Facility Type (check one):

◯ Public Building ◯ Child Care Center ◯ Home

◯ School (pre-K – 12) ◯ Family Daycare ◯ Other

Facility Name:_____ Building Name:_____

Street:_____ City/State/ZIP:_____

Inspector Name:_____ RIDOH License No.: _____

Analytical Service Name:_____ RIDOH License No.: _____

Test type (check one.): ◯ Initial ◯ Follow up ◯ 3-year Retest ◯ Post-Mitigation

Test Start Date	**Test End Date**	**Floor**	**Room/Area**	**Method/Device** (see key)	**Result** (pCi/L or WL)

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Include as many pages as necessary. Indicate the number of pages included on the cover page.