

New York State Department of Environmental Conservation



AIR POLLUTION ODOR AND FALLOUT - COMPLAINT LOG

1) Name _____
Address _____
Telephone No: (Bus.) _____ (Home) _____

2) Have you personally experienced any of the following symptoms which you think might be related to odors?
No Yes (Circle) If yes, identify suspected source and complete the following:

Name _____ Location _____

Wind Direction (from) _____ Wind strength: Strong __ Medium __ Light __ None __

Discomfort Symptoms	<u>Severe</u>	<u>Mild</u>	<u>Date and Time (A.M. or P.M.)</u>	
				Began
Ended				

a) Eye irritation	_____	_____	_____	_____
b) Sneezing	_____	_____	_____	_____
c) Coughing	_____	_____	_____	_____
d) Nausea	_____	_____	_____	_____
e) Other _____	_____	_____	_____	_____

Actions Taken	<u>Date</u>	<u>Time (A.M. or P.M.)</u>
a) Went indoors and shut doors and windows	_____	_____
b) Curtailed activity	_____	_____
c) Took medication	_____	_____
d) Sought medical treatment	_____	_____
e) Called Dept. of Environmental Conservation	_____	_____
f) Called other state or local agency	_____	_____
g) Other _____	_____	_____

3) Have you noticed damage or soiling on your property which you believe to be caused by air pollution?
No Yes (Circle) If yes, identify suspected source and complete the following:

Name _____ Location _____

Date damage/soiling observed _____

Describe damage or soiling _____

4) IMPORTANT: If the State begins legal action against the source, would you be willing to give sworn testimony and to be cross-examined? Yes No (Circle)

5) Signature of complainant _____ Date _____

*Please make additional copies if necessary.

*Please return completed forms to: New York State Department of Environmental Conservation,
270 Michigan Avenue, Buffalo, New York 14203