OSR-2

NEW YORK STATE DEPARTMENT OF HEALTH
OIL SPILL RELOCATION APPLICATION
OCCUPANT PROFILE INFORMATION QUESTIONNAIRE

DEC Spill No. _____ Spill Name:_____

Bldg. Address _____Apt No. _____

No. Occupants in dwelling unit _____(Applicant must fill out section for each household occupant).

Odor Recognition:_____ Do you wish to be relocated?_____

****

Name: _____Age: _____ Sex: _____

Occupation: _____

Pre-existing health conditions:_____

Symptoms: _____

Consulted/Examined by a Physician _____Physician's Name_____

****

Name: _____Age: _____ Sex: _____

Occupation: _____

Pre-existing health conditions:_____

Symptoms: _____

Consulted/Examined by a Physician _____Physician's Name_____

****

Name: _____Age: _____Sex: _____

Occupation: _____

Pre-existing health conditions:_____

Symptoms: _____

Consulted/Examined by a Physician _____Physician's Name_____

****

This form should be returned to: Bureau of Toxic Substance Assessment
NYS Department of Health
Empire State Plaza, Corning Tower, Room 1743
Albany, NY 12237