

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

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? \_\_\_\_\_

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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Occupation: \_\_\_\_\_

Pre-existing health conditions: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Consulted/Examined by a Physician \_\_\_\_\_ Physician's Name \_\_\_\_\_

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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Health conditions: \_\_\_\_\_

Occupation: \_\_\_\_\_

Odor Recognition: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Do you wish to be relocated? \_\_\_\_\_

Consulted/Examined by a Physician \_\_\_\_\_ Physicians Name \_\_\_\_\_

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Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Health conditions: \_\_\_\_\_

Occupation: \_\_\_\_\_

Odor Recognition: \_\_\_\_\_

Symptoms: \_\_\_\_\_

Consulted/Examined by a Physician \_\_\_\_\_ Physicians Name \_\_\_\_\_

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This form should be returned to:

Bureau of Toxic Substance Assessment  
NYS Department of Health  
Flanigan Square, 547 River St.  
Troy, NY 12180-2216