

NEW YORK STATE DEPARTMENT OF HEALTH
OIL SPILL RELOCATION PROGRAM
RELOCATION APPLICATION

Spill No. _____ Spill Name: _____

Responsible party: Name and Address: _____

Phone No. (____) _____

Applicant Name and Address: _____

Phone No. (____) _____

Applicant Signature _____ Date _____

Building information: residential commercial
single family multiple unit: No. units _____
owner occupied rented

Building owner _____ Phone No. _____

Building location with respect to spill: _____

Basis for application: _____

Odors (describe): _____

Was organic vapor monitoring performed: Y / N

Instrument _____ Sampler's Affiliation _____

Calibration Date: _____ Samplers Name: _____

Table with 4 columns: Location, Date/Time, Result, Factors affecting Result*. Includes three rows of blank lines for data entry.

*eg: open windows, probe location

Was air sampling performed: Y / N (If yes, attach air sampling protocol report).

Was occupant profile questionnaire completed by occupant: Y / N

Completed By: _____ Date _____

Agency/Title: _____ Telephone No. (____) _____

This application should be sent to the: Bureau of Toxic Substance Assessment
NYS Department of Health
Flanigan Square 547 River St.
Troy, NY 12180-2216