OSR-1 **9/2012**

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 / single family / owner occupied — commercial / multiple unit: No. units_____ / 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: _____

Location	Date/Time	Result	Factors affecting Result*

*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
Empire State Plaza, Corning Tower, Room 1743
Albany, NY 12237