Global Glare Project
Post Occupancy Evaluation

REFERENCE: 
LOCATION: 
DATE: 
TIME: 

LIGHTING QUESTIONS
1. Please tick any number of options that describe the lighting in your workspace?
   Gloomy □  Dim □  Comfortable □  Bright □  Glary □

2. How would you describe your exterior window view?
   Window with urban view □  Window with natural view □
   Window with only sky view □  No viewing windows □

3. Approximately how long have you worked under these lighting conditions?
   < 1 Week □  < 1 Month □  < 6 Months □  > 6 Months □

DISCOMFORT GLARE
Please click or mark the check the boxes on the view diagram to indicate uncomfortable or distracting glare. Please mark as much of the glare source as possible. If it is possible view the raw camera image to obtain an accurate location on the view diagram.

PERSONAL
1. Do you wear prescription glasses?
   Reading □  Driving □  All the time □  Never □

2. What is your age?
   < 30 □  < 50 □  < 65 □  > 65 □

3. Does your working day consist of predominantly screen based tasks?
   All week □  3-4 days week □  1-2 days week □  Never □