



Grow Room Dehumidifier Sizing Questionnaire

Project Name: _____
Client Name: _____
Phone Number: _____
Address: _____

ROOM TYPE

Mother Flower Propagation Cure Veg. Other

ROOM SIZE

Dimensions (ft/m): _____
Width: _____
Length: _____
Ceiling Height: _____

MATERIAL TYPE

Wall: _____
Ceiling: _____

LIGHTING INFORMATION

Number of Lights: _____
Watts: _____
Voltage: _____
HPS: Yes No
LED: Yes No
Other: _____

AIR CONDITIONING

Type: _____
Tonnage: _____

PLANT/WATER FEED INFORMATION

Number of Plants per Room: _____
Number of Gallons of Water per Day: _____
Percentage of Runoff: _____
Grow Media Type and Size: _____

VENTILATION

Exhaust (CFM): _____
Intake (CFM): _____

DESIRED CONDITIONS

| | Lights On Min. | Lights On Max | Lights Off Min. | Lights Off Max |
|-------------------|----------------|---------------|-----------------|----------------|
| Temperature | | | | |
| Relative Humidity | | | | |

CURE

Total Weight: _____ # of Days to Cure: _____ Room Temperature: _____