Resident Names:_____
Resident Adress: _____

Kitchen	Good	Fair	Poor	Comments
Oven/ Range				
Hood fan				
Dishwasher				
Disposal				
Refridgerator				
Sink/ Faucet				
Cabinets				
Countertops				
Floors				
Walls				
Ceiling				
Other				
Dining Room				
Windows				
Blinds				
Fixtures/ bulbs				
Carpet/ Floor				
Walls				
Ceiling				
Living Room				
Floor/ Carpet				
Walls/ Ceiling				
Blinds				
Windows				
Doors/ Screens				
Fireplace				
Ceiling Fans				
Outlets				
Bedroom 1				
Floor/ Carpet				
Walls/ Ceiling				
Doors				
Windows				
Blinds				
Closet				
Other				
Bedroom 2				
Floor/ Carpet				
Walls/ Ceiling				
Doors				
Windows				
Blinds				
Closet				
Other				

Bathroom 1	Good	Fair	Poor	Comments
Medicine Cabinet				
Vanity/ Mirror				
Toilet				
Sink				
Tile/ Caulking				
Shower Rod				
Shower/ Tub				
Towel Bar				
Walls/ Ceiling				
Fixtures/ Bulbs				
Doors				
Floor				
Linen Closet				
Other				
Bathroom 2				
Medicine Cabinet				
Vanity/ Mirror				
Toilet				
Sink				
Tile/ Caulking				
Shower Rod				
Shower/ Tub				
Towel Bar				
Walls/ Ceiling				
Fixtures/ Bulbs				
Doors				
Floor				
Other				
Bedroom 3				
Floor/ Carpet				
Walls/ Ceiling				
Doors				
Windows				
Blinds				
Closet				
Other				
Bedroom 4				
Floor/ Carpet				
Walls/ Ceiling				
Doors				
Windows				
Closet				
Blinds				
Misc. Items	**Yes**	**No**	**None**	**Other**
Smoke Detectors				
# of Front Door Keys				
Laundry Keys				
Furniture				

A/C Window Unit				