Building Location:_____

Inspection Date:_____

Inspected by whom: _____

Weekly _____

Daily_____

Monthly _____

Scope of Work

Please rate cleanliness from a scale of 1-5 (1=poor, 2=unsatisfied, 3=satisfied, 4=very satisfied, 5=Excellent)

Bathrooms: Toilet Bowl _____ Mirror _____ Dust_____ Vent_____ Countertops_____ Walls_____ Doors front and back _____ Baseboards _____ Bathroom Stalls Above ledges_____ Bathroom Stall Doors _____Floor _____ Behind Toilet Bowl Area_____ Above lighting Area_____ Odor _____ Trash Removal _____

BreakRoom Area: Countertops_____ Floor _____ Microwave _____ Dishwasher_____ Refrigerator Exterior Surfaces _____ Walls _____ Doors _____ Tables _____ Chairs _____ Vents _____ Baseboards _____ Odor _____ Trash Removal _____

Lobby Area: Rugs Vacuum _____ Trash Removal _____ Glass Door Entrances _____ Dust _____ Floor _____ Odor _____

Reception Glass Area ____ Restocking of Supplies _____ Restocking Soap Dispensers _____

Replace Trash Liners _____

Baseboards in Common Areas _____ Overall Cleanliness of the facility _____

Janitor Comments _____

Inspector Comments _____

Inspector Signature _____

Approval Manager Date _____

Approval Manager Signature _____

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