Inspection Date:
Building:
Room:
Inspected By:

Line Item	Pass	Fail
Doorknobs or Door Handles		
Door Jambs		
Door Surface		
Phone		
Over-Bed Table		
Countertop		
Light Switches		
Patient Chair		
All Horizontal Surfaces		
Window Sills		
Medical Equipment		
Walls (Spot Cleaned)		

Notes and immediate action items:

Signature: _____