Monitoring Form – Vermin Control

Establishment: _____ Date Checked: _____

Checked by (Manager): _____

- Check each box with (**Y**) for yes or (**N**) for no.

	Clutter Free	Floors Clean/Good Repair	Walls Clean/Good Repair	No Evidence of Vermin	Corrective Action Taken
Dish Machine Room					
Dry Food Store Room					
Hallway Storage					
Laundry Room					
Fireplace					
Floor Drains					

NOTE: