**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:**