

Unit Check-in Condition List

Upon arrival, please check your apartment completely and list any areas that require cleaning and/or repair. ***Please complete this form and submit it to [Auxiliary Housing](#) within 10 days of key pick-up.***

Name _____ Date: _____

Address _____ Floor _____

Mobile Phone Number: _____ E-mail address _____

General Condition

Is the apartment clean?
Are the appliances clean?

Yes _____
Yes _____

No _____
No _____

Check-In Condition	
Living Room:	
Ceiling/Walls	
Floors	
Windows/Screens/Shades	
Light Fixtures	
Kitchen:	
Ceilings/Walls	
Floor	
Windows/Screens	
Light Fixtures	
Cabinets	
Countertop	
Stove	
Refrigerator	
Sink/Faucets/Stopper	
Bathroom:	
Ceilings/Walls	
Floor	
Windows/Screens/Shade	
Light Fixtures	
Exhaust Fan	
Medicine Cabinet	
Tub/Faucets/Stoppers	
Toilet/Seat	
Bedroom(s):	
Door	
Ceiling/Walls	
Floor	
Windows/Screens/Shades	
Light Fixtures	
Closet	