

Move-Out Inspection Report

RESIDENT: _____ Unit #: _____
 PROPERTY: _____ Move-Out Date: _____

LIVING ROOM	Charge to Resident		
Walls/Base Boards	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Ceiling / Light	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Outlets	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Floor / Carpet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Windows/Coverings	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Doors/Closet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
DINING ROOM			
Walls/Base Boards	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Ceiling / Light	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Outlets	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Floor / Carpet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Windows/Coverings	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Doors/Closet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
KITCHEN			
Walls/Base Boards	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Ceiling / Light	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Outlets	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Floor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Windows/Coverings	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Cabinets / Counters	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Range / Vent Hood	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Refrigerator	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Dishwasher	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Disposal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
HALL			
Walls/Base Boards	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Outlets	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Ceiling / Light	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Floor / Carpet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
BEDROOMS (Specify #)			
Walls/Base Boards	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Outlets	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Ceiling / Light	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Floor / Carpet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Windows/Coverings	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Doors/Closet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
BATHS (Specify #)			
Walls/Base Boards	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Towel/Toilet Paper Holder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Outlets	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Ceiling / Light	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Floor	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Cabinets/Counter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Fixtures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Tub / Shower	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
MISCELLANEOUS			
Smoke Alarm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Fire Extinguisher	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Screens	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Heating / Air	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$

Painting Charge \$ _____ Carpet Shampoo \$ _____ Cleaning Charge \$ _____ Labor \$ _____

RESIDENT FORWARDING ADDRESS: _____

NEW PHONE NUMBER: _____

MANAGER: _____ RESIDENT : _____
 DATE: _____ DATE: _____
 PATTY: _____ DATE: _____