INTERNAL AUDIT

Date of Audit: _____

Facility: _____ CRS#: _____

Department/Area: _____ Supervisor: _____

Auditor: _____ Audit Interval: _____

Audit Recommendations:

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1. FACILITIES AND EQUIPMENT:

	YES	NO	N/A
A. Is ventilation, lighting, temperature, and humidity? control adequate?	___	___	___
B. Is the floor plan laid out in an efficient manner?	___	___	___
C. Are good housekeeping practices being maintained?	___	___	___
D. When problems arise, are they taken care of promptly?	___	___	___