Airborne Infection Isolation Room Checklist

Facility: _____ Month & Year: _____

- Place a **"X"** with the correlating days **when the Isolation Room is NOT in use**
- Place your **initials** in the correlating days **when room is tested AND passes testing**

Date	Isolation RM #	Passed	Failed	Action Taken	Comments:
1					
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31					

Initial	Signature	Initial	Signature	Initial	Signature
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____