



Drywall QC

Project Number:
 Project Name:
 Project Address:
 City / State / ZIP:
 Project Contact:
 Notes:

Report Date:
 Completed By:
 Completed By Email:
 Customer Name:
 Customer Address:
 City / State / ZIP:
 Customer Contact:

General

If any items are marked N (no), add details in the comment field.

#	Item/Question	Yes	No	NA	Comments
1.	Are all materials available and in the area to be installed (drywall, insulation, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Are frame-outs (F.E.C., damper openings, etc.) are clearly marked so they do not get covered?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3.	If caulking is required, are there appropriate gaps at bottom and head of walls?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Are all screws set? (no clickers or shiners)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Are all joints are tight (within 1/8")?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.	Are all off angles installed to create a point?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Acknowledgement

SIGNATURE NAME	SIGNATURE	SIGNATURE DATE/TIME	SIGNATURE NOTE
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