

CUSTOMER PROBLEM ANALYSIS CHECK

Supplemental Restraint System Check Sheet
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 Inspector's
Name _____

Customer's Name		Registration No.	
		Registration Year	/ /
		Frame No.	
Date Vehicle Brought In	/ /	Odometer Reading	km Miles

Date Problem Occurred	/ /
Weather	<input type="checkbox"/> Fine <input type="checkbox"/> Cloudy <input type="checkbox"/> Rainy <input type="checkbox"/> Snowy <input type="checkbox"/> Other
Temperature	Approx. _____

Vehicle Operation	<input type="checkbox"/> Starting <input type="checkbox"/> Idling <input type="checkbox"/> Driving [<input type="checkbox"/> Constant speed <input type="checkbox"/> Acceleration <input type="checkbox"/> Deceleration <input type="checkbox"/> Other]
Road Conditions	
Details Of Problem	

Vehicle Inspection, Repair History Prior to Occurrence of Malfunction (Including Supplemental Restraint System)	
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Diagnosis System Inspection

SRS Warning Light Inspection	1st Time	<input type="checkbox"/> Remains ON <input type="checkbox"/> Sometimes Light Up <input type="checkbox"/> Does Not Light Up
	2nd Time	<input type="checkbox"/> Remains ON <input type="checkbox"/> Sometimes Light Up <input type="checkbox"/> Does Not Light Up
DTC Inspection	1st Time	<input type="checkbox"/> Normal Code <input type="checkbox"/> Malfunction Code [Code.]
	2nd Time	<input type="checkbox"/> Normal Code <input type="checkbox"/> Malfunction Code [Code.]