

CUSTOMER PROBLEM ANALYSIS CHECK

BODY CONTROL SYSTEM Check Sheet

Inspector's name: _____

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

Date Problem First Occurred	/ /
Frequency Problem Occurs	<input type="checkbox"/> Constant <input type="checkbox"/> Sometimes (times per day, month) <input type="checkbox"/> Once only
Weather Conditions When Problem Occurred	Weather <input type="checkbox"/> Fine <input type="checkbox"/> Cloudy <input type="checkbox"/> Rainy <input type="checkbox"/> Snowy <input type="checkbox"/> Various/ Others
	Outdoor Temperature <input type="checkbox"/> Hot <input type="checkbox"/> Warm <input type="checkbox"/> Cool <input type="checkbox"/> Cold (Approx. °F (°C))

Malfunction System	<input type="checkbox"/> Key Reminder System
	<input type="checkbox"/> Light Control System
	<input type="checkbox"/> Illuminated Entry System
	<input type="checkbox"/> Seat Belt Warning
	<input type="checkbox"/> Power Window Control System
	<input type="checkbox"/> Power Door Lock Control System
	<input type="checkbox"/> Wireless Door Lock Control System
	<input type="checkbox"/> Others