

Vehicle Inspection Record

T-00101

Inspection must be completed each time the vehicle is used in the shop for pm work. Specify any problems in the remarks section.

VEHICLE NUMBER	ODOMETER READING
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N/A	ok	X		N/A	OK	X		N/A	OK	X		N/A	OK	X	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headlights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Windshield	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emergency Triangles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clearance Lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wipers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lift Gate	_____			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Turn Signals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	A/C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Engine Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hazards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heater	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No Power	_____			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brake Lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Floor/Seats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Engine Knocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reverse Lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seat Belts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leaks	_____			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dash Lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interior Clean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transmission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Horn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Door(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Steering	_____			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Windows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Accident Packet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brake(s) All	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mirrors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fire Extinguisher	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tires/Wheels	_____			

BODY DAMAGE

CHECK HERE IF NO NEW DAMAGE



REMARKS _____

WORK DONE REMARKS _____

SUPERVISOR

MECHANIC'S SIGNATURE

DATE TIME