DI6OX–01

CUSTOMER PROBLEM ANALYSIS CHECK

Supplemental Restraint System Check Sheet

Inspector's Name _____

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

Date Problem Occurred	/ /
Weather	☐ Fine ☐ Cloudy ☐ Rainy ☐ Snowy ☐ Other
Temperature	**Approx.**

Vehicle Operation	☐ Starting ☐ Idling ☐ Driving [☐ Constant speed ☐ Acceleration ☐ Deceleration ☐ Other]
Road Conditions	
Details Of Problem	

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

Diagnosis System Inspection

SRS Warning Light Inspection	**1st Time**	☐ Remains ON ☐ Sometimes Lights Up ☐ Does Not Light Up
	2nd Time	☐ Remains ON ☐ Sometimes Lights Up ☐ Does Not Light Up
DTC Inspection	**1st Time**	☐ Normal Code ☐ Malfunction Code [Code.]
	2nd Time	☐ Normal Code ☐ Malfunction Code [Code.]