

CUSTOMER PROBLEM ANALYSIS CHECK

ABS Check Sheet

Inspector's Name _____

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

Date Problem First Occurred	/ /
Frequency Problem Occurs	<input type="checkbox"/> Continuous <input type="checkbox"/> Intermittent (times a day)

Symptoms	<input type="checkbox"/> ABS does not operate.	
	<input type="checkbox"/> ABS does not operate intermittently.	
	ABS Warning Light Abnormal	<input type="checkbox"/> Remains ON <input type="checkbox"/> Does not Light Up

DTC Check	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)