



**(This form must be included with the OES-PSC-213 for invoicing)**

VIN: \_\_\_\_\_ Date In: \_\_\_\_\_ Date Out: \_\_\_\_\_

PSC Billing Code: \_\_\_\_\_ Agency / Institution Code: \_\_\_\_\_  
*(Required)* *(For PSC Use Only)*

Customer Name:

Customer Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Customer Quality Assurance Checklist** *(Initials Required for In-Out)*

	IN	OUT		IN	OUT
Headlights, low-beam	_____	_____	AM/FM Radio	_____	_____
High Beam	_____	_____	Air Conditioner	_____	_____
Turn Signals, Left	_____	_____	Heater	_____	_____
Turn Signals, Right	_____	_____	Cigarette Lighter	_____	_____
Flashers	_____	_____	Interior Lights	_____	_____
Break Lights	_____	_____	Back-up Lights	_____	_____
Power Windows	_____	_____	Power Door Locks	_____	_____
Trunk Lock	_____	_____	Power Mirrors	_____	_____
Vehicle Alarm	_____	_____	Cell Phone	_____	_____
Horn	_____	_____			

Vehicle Body Damage:

Technician Name: \_\_\_\_\_ DC # \_\_\_\_\_  
*(Check out Technician)*

Comments: