

APPENDIX 1

SCANNED
MAY 13 2009
U.S. DISTRICT COURT MP:LS



Fatigued Driving Evaluation Checklist

Inspector:

Inspection #:

Carrier DOT #:	Driver Name:	Date of Examination:
Overall Truck Condition <input type="checkbox"/> Exterior Dirty/Unkempt <input type="checkbox"/> Vehicle Maintenance Not Performed <input type="checkbox"/> Trailer Interior Dirty/Unkempt <input type="checkbox"/> Obvious Lack of Overall Care <input type="checkbox"/>	Driving Behaviors <input type="checkbox"/> Speed - Change Speed/No Apparent Reason <input type="checkbox"/> Lane Position - Weaving <input type="checkbox"/> Missed Turn <input type="checkbox"/> Missed Red Light/Stop Sign/Etc. <input type="checkbox"/> Fail To Respond To Traffic Situations <input type="checkbox"/> Tailgating <input type="checkbox"/> Unnecessary Braking <input type="checkbox"/> Fail to Use Turn Signals <input type="checkbox"/> Crash <input type="checkbox"/> HOS Violation <input type="checkbox"/> Log Not Current <input type="checkbox"/> No Log Book Present <input type="checkbox"/> False log <input type="checkbox"/>	Driver Physical Condition <input type="checkbox"/> Driver: Dirty/Disheveled <input type="checkbox"/> Unshaven <input type="checkbox"/> Lack of Attention/Unable to Maintain Focus <input type="checkbox"/> Eyes: Bloodshot <input type="checkbox"/> Eyes: Watery/Tearing <input type="checkbox"/> Yawns During Interview <input type="checkbox"/> Clothing: Dirty/Disheveled <input type="checkbox"/> Driver Ill <input type="checkbox"/> Head Bobbing <input type="checkbox"/> Droopy Eyelids <input type="checkbox"/> Distant Stare <input type="checkbox"/> Use of OTC Medications <input type="checkbox"/> Use of Prescription Meds <input type="checkbox"/> Use of Contraband Substances <input type="checkbox"/> Alcohol Detected <input type="checkbox"/> Job/Home related stress <input type="checkbox"/> Appears Irritable <input type="checkbox"/> Allergies <input type="checkbox"/> Use of Caffeine or Stimulants <input type="checkbox"/> Noticeable Body Odor <input type="checkbox"/> Money concerns <input type="checkbox"/> Physical movements/ rubbing head, face, eyes <input type="checkbox"/> Easily confused or slow to respond <input type="checkbox"/> Overly agreeable - Overly quick to agree <input type="checkbox"/>
Condition of Sleeper <input type="checkbox"/> No Bedclothing & Blanket <input type="checkbox"/> No Mattress <input type="checkbox"/> Berth Does NOT Qualify as Sleeper Berth 393.76 <input type="checkbox"/> Items/Debris/Tools on Mattress <input type="checkbox"/> Berth Obviously Unused <input type="checkbox"/> Television in Berth - DVD's Video's <input type="checkbox"/> Clothing In Berth <input type="checkbox"/> Video game system <input type="checkbox"/> Reading material - books, magazines, papers <input type="checkbox"/>	Driver Medical Condition <input type="checkbox"/> Snoring <input type="checkbox"/> Diagnosed with Sleep Apnea <input type="checkbox"/> CPAP Machine <input type="checkbox"/> Restless Leg Syndrome (RLS) <input type="checkbox"/> Acid Reflux Condition <input type="checkbox"/> Dental Problems <input type="checkbox"/> Grinding of Teeth (Bruxism) <input type="checkbox"/> Active dreams <input type="checkbox"/> Sleepwalking <input type="checkbox"/>	
Condition of Cab <input type="checkbox"/> Debris in Cab <input type="checkbox"/> Wastebasket Full/Overflowing <input type="checkbox"/> Food or Food Wrappers in Cab <input type="checkbox"/> Urine Bottle Present <input type="checkbox"/> Clothing in Cab <input type="checkbox"/> Empty Soda/Caffeinated Drink Cans/Bottles <input type="checkbox"/> Pets in Vehicle <input type="checkbox"/> Cell Phone <input type="checkbox"/> Computer <input type="checkbox"/>		

_____ Total Hours of Last Sleep Period
 _____ Total Hours of Sleep Last 24 Hrs
 _____ Hours since Last Sleep Period

_____ Hours Since Last Rest Stop/Bathroom Break

_____ Driver Height
 _____ Driver Weight
 _____ Driver Neck Size

DRIVER: Rate your Alertness Level 1 <input type="checkbox"/> Completely Alert 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> Moderately Tired 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Extremely Tired/Worn Out	Notes:
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