Weekly Vehicle Inspection Checklist

Driver Name		Vehicle License Number	
Make / Model		Mileage/ Hours	

Lights	Satisfactory		Comments
Headlights – high and low beam	☐ Yes	☐ No	
Parking Lights	☐ Yes	☐ No	
Turn Signal	☐ Yes	☐ No	
Tail Lights	☐ Yes	☐ No	
Brake Lights	☐ Yes	☐ No	

Fluids and Lubricants	Satisfactory		Comments
Engine Oil	☐ Yes	☐ No	
Coolant Fluid	☐ Yes	☐ No	
Transmission Fluid	☐ Yes	☐ No	
Power Steering Fluid	☐ Yes	☐ No	
Brake Fluid	☐ Yes	☐ No	
Clutch Fluid	☐ Yes	☐ No	
Battery Fluid	☐ Yes	☐ No	
Windshield Washer Fluid	☐ Yes	☐ No	

Tires	Satisfactory		Comments
Pressure	☐ Yes	☐ No	
Tread Depth	☐ Yes	☐ No	
Condition	☐ Yes	☐ No	

General	Satisfactory		Comments
Horn	☐ Yes	☐ No	
Mirrors	☐ Yes	☐ No	
Wiper Blades	☐ Yes	☐ No	
Seat Belts	☐ Yes	☐ No	

Submit checklist to Fleet Project Manager every Monday.

Inspection Performed by:

Employee Name:_____   Signature:_____

Date:_____   Time:_____