



**DAVE'S
VALLEY AUTO CLINIC INC.**
COMPLETE AUTOMOTIVE SERVICE

Customer Name _____

Address _____

City _____ Zip _____

Home Phone _____ Business Phone _____

Email Address _____

YEAR _____

MAKE _____

MODEL _____

COLOR _____

LICENSE PLATE _____



- | | |
|--|--|
| <input type="checkbox"/> Change Oil and Filter | <input type="checkbox"/> Check Engine Light On |
| <input type="checkbox"/> Tire Rotation | <input type="checkbox"/> Engine Running Poorly |
| <input type="checkbox"/> Transmission Service | <input type="checkbox"/> Low Fuel Mileage |
| <input type="checkbox"/> Brake Inspection | <input type="checkbox"/> Vibration or Noise |
| <input type="checkbox"/> Inspect Tires | <input type="checkbox"/> _____ Mile Service |
| <input type="checkbox"/> Pre-Trip Inspection | <input type="checkbox"/> Replace Wipers |

Other Services Needed/Description of Problem

Customer Signature _____