

From: _____ Date: _____

Estimated Cost: _____

OD / TP / WS / TP RES / OD RES / EVA / INV / MV

To Inspect Vehicle No: _____

at Workshop m/s _____

of _____

Insured: _____

Policy No. _____

Claims No. _____

Sum Insured: _____ Excess: _____

(Client's Record)

Make of Veh: _____

Remark: The veh had commenced its
repair at the time of inspection.

	
N/S	O/S
	

Date: _____ Person Contacted: _____

The U/C / Chassis frame / Body Structure affected due to collision.

TOTAL
