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Flexible Sleeper Berth – Background Questionnaire

*Information on this form will be kept confidential within the research team
and will not be shared with your company.*

**Please answer all questions as accurately as possible.**

1. What is your age? \_\_\_\_\_\_\_\_\_ years
2. Gender: ☐ Male ☐ Female
3. How tall are you? \_\_\_\_\_\_ feet \_\_\_\_\_ inches
4. What is your weight? \_\_\_\_\_\_\_\_\_\_\_\_ pounds (lbs)
5. Years of commercial driving experience \_\_\_\_\_\_\_\_\_\_\_\_ years
6. Do you have a million miler safety record? ☐ Yes ☐ No
	1. If yes: ☐ 1 million miles ☐ 2 million miles ☐ 3 million miles
7. Have you taken any modules from the North America Fatigue Management Program? ☐ Yes ☐ No
	1. If yes, check all that apply:

☐ Module 1: FMP Introduction and Overview

☐ Module 2: Safety Culture and management Practices

☐ Module 3: Driver Education

☐ Module 4: Driver Family Education

☐ Module 5: Train-the-Trainer for Driver Education and Family Forum

☐ Module 6: Shippers and Receivers

☐ Module 7: Motor Carrier Sleep Disorders Management

☐ Module 8: Driver Sleep Disorders Management

☐ Module 9: Driver Scheduling and Tools

☐ Module 10: Fatigue Monitoring and Management Technologies

1. How long have you worked at your present company? \_\_\_\_\_\_\_years \_\_\_\_\_\_\_months
2. Type of driver: ☐ Day ☐ Night ☐ Mixed
3. What is your home terminal time zone used for HOS logs?

☐ Eastern ☐ Central ☐ Mountain ☐ Pacific

1. What is your driving type?

 ☐ Local ☐ Regional ☐ Over-The-Road

1. What is your operational type?

☐ Intermodal ☐ Dedicated

☐ Flatbed ☐ Temperature control

☐ Van truckload ☐ Other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What type of CDL endorsement/restrictions do you have? (Check all that apply.)

☐ Air brakes restriction (L) ☐ Intrastate only (K)

☐ Passenger (P) ☐ Double/triple trailer (T)

☐ Tank (N) ☐ HazMat (H)

☐ Tank and HazMat (X) ☐ Other, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What type of trailer do you typically use?

☐ Dry Van (Box Trailer) ☐ Flatbed Trailer ☐ Tank Trailer (Tanker)

☐ Refrigerated Trailer ☐ Specialized Trailer

1. Is your truck equipped with any of the following? (Check all that apply.)

☐ Auxiliary Power Unit ☐ Espar Heater

☐ Optimized Idle ☐ Other Idle Reduction Technology: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you ever use platooning? ☐ Yes ☐ No
2. Do you wear contact lenses? ☐ Yes ☐ No
3. Do you wear glasses when driving? ☐ Yes     ☐ No
4. Has a physician informed you that you have any of the following conditions? (Mark all that apply to you.)

☐ Sleep apnea ☐ Diabetes

 ☐ High blood pressure ☐ Insomnia

1. Do you use any of the following? (Mark all that apply to you)

☐ CPAP for sleep apnea ☐ Medication for diabetes

☐ Medication for high blood pressure ☐ Medication for insomnia

1. How often do you experience pain of any kind during a typical daily work shift? (Check only 1 box)

☐ 0–5% of shift ☐ 5–25% of shift ☐ 25–50% of shift ☐ 50–75% of shift ☐ 75% or more of shift

1. Do you typically consume caffeine?

☐ No ☐ Yes (If yes, for all categories that apply, indicate amount consumed in a typical day.)

 Coffees \_\_\_\_\_\_\_ cups per day Cola drinks \_\_\_\_\_\_\_ drinks per day

 Energy drinks \_\_\_\_\_\_\_ drinks per day Caffeine pills \_\_\_\_\_\_\_ pills per day

 Caffeine gum \_\_\_\_\_\_\_ sticks/pieces per day Tea (not herbal) \_\_\_\_\_\_\_ cups per day

1. Do you typically use tobacco or nicotine products?

☐ No ☐ Yes (If yes, for all categories that apply, indicate amount used in a typical day.)

 Cigarettes \_\_\_\_\_\_\_ cigarettes per day Cigars \_\_\_\_\_\_\_ cigars per day

 Chew tobacco \_\_\_\_\_\_\_ pinches/pouches per day Smoke pipe \_\_\_\_\_\_\_ bowls per day

 Nicotine gum \_\_\_\_\_\_\_ sticks/pieces per day E-cigarettes \_\_\_\_\_\_\_ mL per day (w/nicotine)
 \_\_\_\_\_\_\_mg nicotine per mL

***Thank you!***