OMB NO: XXXX-XXXX
EXPIRATION DATE: mm/dd/yyyy

Participant ID: _____

Public Burden Statement

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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
    a. 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
    a. 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

8. How long have you worked at your present company? _____years _____months

9. Type of driver: ☐ Day ☐ Night ☐ Mixed

10. What is your home terminal time zone used for HOS logs?

☐ Eastern ☐ Central ☐ Mountain ☐ Pacific

11. What is your driving type?

☐ Local ☐ Regional ☐ Over-The-Road

12. What is your operational type?

☐ Intermodal ☐ Dedicated
☐ Flatbed ☐ Temperature control
☐ Van truckload ☐ Other, please specify _____

13. 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 _____

14. What type of trailer do you typically use?

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

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

☐ Auxiliary Power Unit ☐ Espar Heater
☐ Optimized Idle ☐ Other Idle Reduction Technology: _____

16. Do you ever use platooning? ☐ Yes ☐ No

17. Do you wear contact lenses? ☐ Yes ☐ No

18. Do you wear glasses when driving? ☐ Yes ☐ No

19. 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

20. 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

21. 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

22. 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

23. 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!