

STUDY: Research on Passenger Car Driver Interactions with
Driver Assistance Technologies

STERLING IRB ID: 7780-EMazzae

DATE OF IRB REVIEW: 02/03/20

Under the Paperwork Reduction Act, a federal agency may not conduct or sponsor, and a person is not required to respond to collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control number. The OMB Control Number for this information collection is 2127-NEW (expiration date: MM/DD/YYYY). The average amount of time to complete the survey is 20 minutes. All responses to this collection of information are voluntary. If you have comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden send them to Information Collection Clearance Officer, National Highway Traffic Safety Administration, 1200 New Jersey Ave, S.E., Washington, DC, 20590.

Screening Questions

The following questions will help us determine your eligibility for study participation.

Questions will cover: (1) personal information, (2) driving experience, and (3) health issues that may impact driving ability.

Note that we (NHTSA and TRC Inc.) will not release any personal identifying information or health information that you provide. The information gathered will be kept confidential and stored in a password-protected database on a protected computer. Responses to health-related questions will not be stored; only a yes or no indication of whether you have a condition that does not meet study criteria will be retained. Any retained personal information will be deleted at the end of the study. While each of the following questions is required for determining eligibility, completing the survey is completely voluntary. You do not have to answer any question that you do not want to answer and can stop at any time.

Are you able to read, write, speak, and understand English without assistance? *

Yes No

Do you have normal, or corrected-to-normal vision in both eyes? *

Yes No

Do you have normal, or corrected-to-normal hearing in both ears? *

Yes No

Are you able to drive an automatic transmission without assistive devices or special equipment?

*

Yes No

Do you currently have any of the following medical issues that may impact your ability to drive continuously for a 3-hour period?

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- Current inner ear, dizziness, vertigo, or balance problems
- Current respiratory disorder/disease or any condition that requires oxygen
- Any epileptic seizures or lapses of consciousness within the past 12 months
- Condition or injury resulting in decreased motor control or cognitive ability condition that might affect your ability to concentrate while driving, such as Attention-Deficit/Hyperactivity Disorder (ADHD) or anxiety *

Yes No

Does anyone in your household work in or is retired from an automotive manufacturer? *

Yes No

Have you had any criminal convictions in the past 3 years? *

Yes No

Study participants must have no more than 2 points on their driving record.

Please enter your Driver License Number so that your driving record status can be confirmed: *

AVAILABILITY FOR PARTICIPATION

Do you have a preferred time of day for participation? *

Morning Afternoon Evening Any Time

	Morning	Afternoon	Evening	Any Time
Mon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thurs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fri	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please enter your contact information so we can match your responses with the information you've already submitted and contact you to schedule your participation.

E-mail address: *

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First Name *	Last Name *
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Street Address *

City *	State *	Zip Code *
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Phone Number - HOME *	Phone Number - Mobile *
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Can we use text messaging to help with scheduling? *

Yes No

Thank you! Please press Submit now.

Submit

If a participant with an out-of-state license submits answers to the screening questions, this participant will be contacted directly to securely provide his/her social security number. This is a requirement from the insurance provider.