

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                  |                                |                                 |                                      |                                      |                                |                                     |                                   |                                      |                                      |                                      |                              |                                |                                   |                                    |            |                                  |                               |                                |                                      |                              |                                |                                     |                                   |                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--------------------------------|---------------------------------|--------------------------------------|--------------------------------------|--------------------------------|-------------------------------------|-----------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|------------------------------|--------------------------------|-----------------------------------|------------------------------------|------------|----------------------------------|-------------------------------|--------------------------------|--------------------------------------|------------------------------|--------------------------------|-------------------------------------|-----------------------------------|--------------------------------------|
| Name: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                  | Date: _____                    |                                 | Event: _____                         |                                      |                                |                                     |                                   |                                      |                                      |                                      |                              |                                |                                   |                                    |            |                                  |                               |                                |                                      |                              |                                |                                     |                                   |                                      |
| City: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                  | State: _____                   |                                 | Track: _____                         |                                      |                                |                                     |                                   |                                      |                                      |                                      |                              |                                |                                   |                                    |            |                                  |                               |                                |                                      |                              |                                |                                     |                                   |                                      |
| <table style="width:100%; font-size: 0.8em;"> <tr> <td>Track</td> <td><input type="checkbox"/> Indoor</td> <td><input type="checkbox"/> Tight</td> <td><input type="checkbox"/> Smooth</td> <td><input type="checkbox"/> Hard Packed</td> <td><input type="checkbox"/> Blue Groove</td> <td><input type="checkbox"/> Wet</td> <td><input type="checkbox"/> Grass</td> <td><input type="checkbox"/> Low Bite</td> <td><input type="checkbox"/> High Bite</td> </tr> <tr> <td>Conditions</td> <td><input type="checkbox"/> Outdoor</td> <td><input type="checkbox"/> Open</td> <td><input type="checkbox"/> Rough</td> <td><input type="checkbox"/> Loose/Loamy</td> <td><input type="checkbox"/> Dry</td> <td><input type="checkbox"/> Dusty</td> <td><input type="checkbox"/> Astro Turf</td> <td><input type="checkbox"/> Med Bite</td> <td><input type="checkbox"/> Other _____</td> </tr> </table> |                                  |                                |                                 |                                      |                                      | Track                          | <input type="checkbox"/> Indoor     | <input type="checkbox"/> Tight    | <input type="checkbox"/> Smooth      | <input type="checkbox"/> Hard Packed | <input type="checkbox"/> Blue Groove | <input type="checkbox"/> Wet | <input type="checkbox"/> Grass | <input type="checkbox"/> Low Bite | <input type="checkbox"/> High Bite | Conditions | <input type="checkbox"/> Outdoor | <input type="checkbox"/> Open | <input type="checkbox"/> Rough | <input type="checkbox"/> Loose/Loamy | <input type="checkbox"/> Dry | <input type="checkbox"/> Dusty | <input type="checkbox"/> Astro Turf | <input type="checkbox"/> Med Bite | <input type="checkbox"/> Other _____ |
| Track                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> Indoor  | <input type="checkbox"/> Tight | <input type="checkbox"/> Smooth | <input type="checkbox"/> Hard Packed | <input type="checkbox"/> Blue Groove | <input type="checkbox"/> Wet   | <input type="checkbox"/> Grass      | <input type="checkbox"/> Low Bite | <input type="checkbox"/> High Bite   |                                      |                                      |                              |                                |                                   |                                    |            |                                  |                               |                                |                                      |                              |                                |                                     |                                   |                                      |
| Conditions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> Outdoor | <input type="checkbox"/> Open  | <input type="checkbox"/> Rough  | <input type="checkbox"/> Loose/Loamy | <input type="checkbox"/> Dry         | <input type="checkbox"/> Dusty | <input type="checkbox"/> Astro Turf | <input type="checkbox"/> Med Bite | <input type="checkbox"/> Other _____ |                                      |                                      |                              |                                |                                   |                                    |            |                                  |                               |                                |                                      |                              |                                |                                     |                                   |                                      |

## Front Suspension

Toe: \_\_\_\_\_

Ride Height: \_\_\_\_\_

Camber: \_\_\_\_\_

Caster: ☐ 0° ☐ 3° ☐ 5° ☐ 10°

Kick Angle: ☐ 20° ☐ 25° ☐ 30°

Sway Bar: \_\_\_\_\_

Oil: \_\_\_\_\_

Piston: \_\_\_\_\_

Spring: \_\_\_\_\_

Spindle Type: ☐ Inline ☐ Trailing

Shock Limiters: \_\_\_\_\_

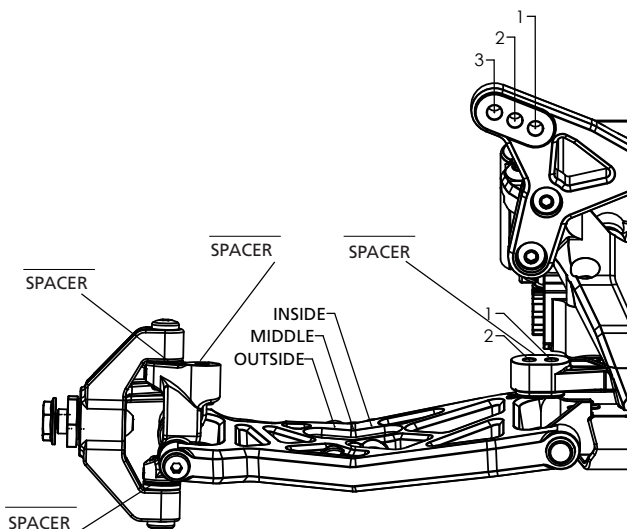
Shock Location: \_\_\_\_\_

Bump Steer: \_\_\_\_\_

Camber Link: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Rear Suspension

Chassis Configuration: ☐ Rear Motor ☐ Mid Motor

Toe: \_\_\_\_\_

Anti-Squat: \_\_\_\_\_

Roll Center: ☐ Low Roll Center (LRC) ☐ High Roll Center (HRC)

Ride Height: \_\_\_\_\_

Camber: \_\_\_\_\_

Rear Hub Spacing: \_\_\_\_\_

Hex Width: \_\_\_\_\_

Sway Bar: \_\_\_\_\_

Oil: \_\_\_\_\_

Piston: \_\_\_\_\_

Spring: \_\_\_\_\_

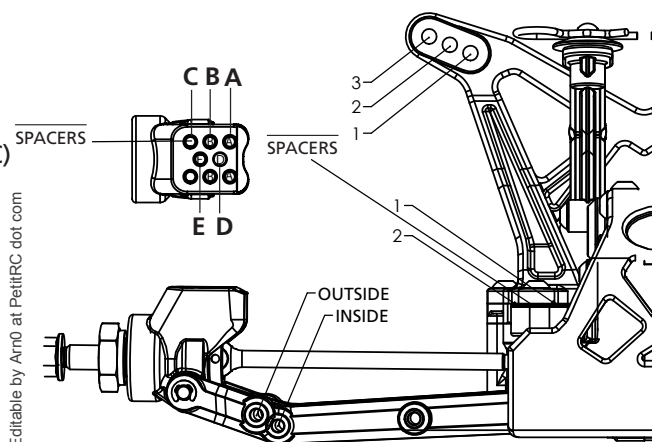
Shock Limiters: \_\_\_\_\_

Camber Link: \_\_\_\_\_

Shock Locations: \_\_\_\_\_

Wing/Wickerbill: \_\_\_\_\_

Battery Position: \_\_\_\_\_



Editable by Arn0 at PettitRC dot com

## Electronics

|                         |                            |
|-------------------------|----------------------------|
| Radio: _____            | Timing Advance: _____      |
| Servo: _____            | Throttle/Brake Expo: _____ |
| ESC: _____              | Servo Expo: _____          |
| Initial Brake: _____    | Throttle/Brake EPA: _____  |
| Drag Brake: _____       | Motor: _____               |
| Throttle Profile: _____ | Pinion: _____ Spur: _____  |
|                         | Battery: _____             |

Weight Placement  
(Mark with "X")



Weight of  
each piece \_\_\_\_\_ oz./g

| Tires        | Compound | Insert | Additive |
|--------------|----------|--------|----------|
| Front: _____ | _____    | _____  | _____    |
| Rear: _____  | _____    | _____  | _____    |
| Notes: _____ | _____    |        |          |