Ergonomics Assessment Request

Please provide the following information in your request. This information provides valuable information used during the assessments.

Date of request:

Last name:

First name:

Department:

Title:

Building number where your office is located:

Room number:

Phone number:

Have you had an ergonomic assessment before?

Yes

No

Is this request due to an employee injury report?

Yes

No

Work schedule / days per week:
Indicate number of days per week worked (example 5 days per week)

Work schedule / hours per day:
Indicate number of hours per day worked (example 8 hours a day)

Are you experiencing any physical symptoms?
Please indicate affected body part and type of symptom (example lower back pain)