ERGONOMIC ASSESSMENT REQUEST FORM

Please complete and return to the Safety & Risk Management Department via e-mail at ehs@sbccd.edu along with the Employee Ergonomic Self-Assessment Form.

SECTION I - TO BE COMPLETED BY THE INDIVIDUAL

Name		Date
E-mail Address	Phone Number	
Job Title	Campus/Department	Office Location
Supervisor's Name	Supervisor's Phone Number	
REASON FOR REQUEST (Check all that apply)	☐ New Hire ☐ New Workstation ☐ Employee Request ☐ Supervisor Request Other: _____	

SECTION II – WORK ACTIVITY

This questionnaire is designed to help us help you adapt/adjust your office workstation and/or equipment to help prevent common stresses and discomforts. Please indicate the average number of hours or minutes you spend each day doing the following tasks:

Computer Use: _____ min. / hrs.	Sitting: _____ min. / hrs.
Typing (Keyboard): _____ min. / hrs.	Standing: _____ min. / hrs.
Mouse: _____ min. / hrs.	Field work: _____ min. / hrs.
Telephone Use: _____ min. / hrs.	Lifting, bending, or twisting: _____ min. / hrs.
	Equipment/Machinery/Tool: _____ min. / hrs.

SECTION III – PHYSICAL DISCOMFORT

☐ Not experiencing discomfort ☐ Has had some discomfort in the past ☐ Currently in discomfort ☐ Discomfort interferes with work	☐ Head ☐ Neck ☐ Back ☐ Lower Back	☐ Eyes ☐ Legs ☐ Ankles ☐ Knees	☐ Right shoulder ☐ Right elbow/forearm ☐ Right wrist /hand /fingers ☐ Right thumb	☐ Left shoulder ☐ Left elbow/forearm ☐ Left wrist /hand /fingers ☐ Left thumb
Other: _____				

I certify that the information included on this form is true and accurate to the best of my knowledge. I also certify that I have completed the Employee Ergonomic Self-Assessment Form prior to the completion of this request form.

_____ _____

Employee Signature Date

SECTION IV- TO BE COMPLETED BY SAFETY & RISK MANAGEMENT DEPARTMENT

_____ _____

District Representative Name Date