



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)	<input type="checkbox"/> New Hire	<input type="checkbox"/> New Workstation
	<input type="checkbox"/> Employee Request	<input type="checkbox"/> 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

<input type="checkbox"/> Not experiencing discomfort <input type="checkbox"/> Has had some discomfort in the past <input type="checkbox"/> Currently in discomfort <input type="checkbox"/> Discomfort interferes with work	<input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Back <input type="checkbox"/> Lower Back	<input type="checkbox"/> Eyes <input type="checkbox"/> Legs <input type="checkbox"/> Ankles <input type="checkbox"/> Knees	<input type="checkbox"/> Right shoulder <input type="checkbox"/> Right elbow/forearm <input type="checkbox"/> Right wrist /hand /fingers <input type="checkbox"/> Right thumb	<input type="checkbox"/> Left shoulder <input type="checkbox"/> Left elbow/forearm <input type="checkbox"/> Left wrist /hand /fingers <input type="checkbox"/> 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 and the Keenan SafeColleges Office Ergonomics training 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
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