Ergonomic Evaluation Request Form

CAL STATE LA

EMPLOYEE INFORMATION		
Employee Name: *(print clearly)* Last, First		**Today's Date:**
Job Title:	**Job Location:**	**Contact Number:**
Department:	**Supervisor's Name:**	**Supervisor's Phone:**

REASON FOR REQUEST (Check all that apply)		
	☐ **New Hire**	☐ **New Workstation/Job Task**
	☐ **Employee's Request**	☐ **Medical Certification**
	☐ **Supervisor's Request**	☐ **Other:** _____

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.
Typing (10-Key):	_____ min. / hrs.	Lifting, bending, or twisting:	_____ min. / hrs.
Mouse:	_____ min. / hrs.	Field Work:	_____ min. / hrs.
Telephone Use:	_____ min. / hrs.	Equipment/Machinery/Tool: **(e.g. Facilities)**	_____ min. / hrs.

If you wear prescription glasses, please check the box if they are needed for computer use: ☐

Physical Discomfort

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

☐ **Other:** _____

_____

EMPLOYEE SIGNATURE **DATE**

Email completed form to: ergo@calstatela.edu