WORKSTATION ERGONOMICS EVALUATION FORM

Ergonomic Assessor Name_____ Date_____

EMPLOYEE INFORMATION

Employee Name: _____ Phone: _____ E-mail: _____

Dept: _____ Location (Building/Address + Rm No.): _____

Job Title: _____ Supervisor Name: _____ Email: _____

Reason for Evaluation: ○ New hire ○ Office move ○ Employee requested ○ Other: _____

Computer Use: hours per day _____ days per week _____ Workstation Location sdf

Additional Info: _____

DISCOMFORT RELATED TO COMPUTER WORK

○ Not experiencing discomfort ○ Has had some discomfort in past ○ Currently experiencing discomfort ○ Experiencing pain/injury ○ Other:	Location of Discomfort, or Pain ☐ Neck ☐ R/L Shoulder ☐ Back ☐ R/L Elbow/Forearm ☐ Legs ☐ R/L Wrist/Hand ☐ Eyes ☐ R/L Thumb	Duration of Current Discomfort: ○ under 2 wks ○ ***over 2 wks***	Employee has notified supervisor and/or Risk Services about pain/injury? sdfs

CHAIR	NOTES:
Chair Make/Model: Issues (if any):	

DESK	NOTES:
Desk Type:	

MOUSE / POINTING DEVICE	NOTES:
Mouse Type:	

MONITOR	NOTES:
Monitor Arrangement:	

KEYBOARD	NOTES:
Make/Model:	

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TELEPHONE	NOTES
Landline used? Cell phone used? Headset needed?	

WORKSTATION GENERAL	NOTES
Workspace layout, lighting, etc. (describe any issues):	

WORK HABITS	NOTES
Body alignment, micro-breaks, movement:	

ADDITIONAL NOTES
Referred to Ergonomic Showroom for chair fitting, or other reason? Other comments: