Proactive Ergonomic Evaluation Request Form

Complete Form, Save, and Email

REQUESTOR

Request Date:

Employee ID:

Department:

First Name:

Last Name:

Phone:

Email:

Address/Physical Location (Pod Number):

REASON FOR REQUEST:

Type of Ergonomic Evaluation: ☐ Office ☐ Multi-User Hoteling ☐ Other

Do you have a current workers' compensation claim for a repetitive motion or cumulative trauma injury or an injury or medical condition not covered by workers' compensation but could benefit from an adjustment to your work station?

☐ **Yes** This request will be forwarded to your Supervisor so that you can access options that may exist under the workers compensation system and/or the County's policy on reasonable accommodation.

☐ **No** Your department supports employees' requests for ergonomic evaluations and making adjustments to your workstation as may be needed.

SAFETY COORDINATOR (If known)

Safety Coordinator Name:

Safety Coordinator Email:

FISCAL OFFICER (If known)

Fiscal Officer Name:

Fiscal Officer Email:

SUPERVISOR

Do you have your Supervisor's approval? ☐ **Yes** ☐ **No**

Supervisor's Name:

Supervisor's Email:

Supervisor's Phone: