ERGONOMIC EVALUATION CHECKLIST

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Part I: Employee Information

Date of Workstation Evaluation:	Employee Name:	Employee Number:
Employee Job Title:	Name of Office/Facility :	Supervisor Name:
Work Address:		Telephone number:
Hand Dominance: ☐Right ☐Left Palm Size: (if necessary)_____ inches	Weight range: Under ☐ 250 lbs. ☐ 250- 300 lbs. ☐ Over 300 lbs.	Employee's: Height: _____ Feet _____ Inches
Job Tasks: _____		

Part II: Reason for the Evaluation

☐ New workstation (Prior workstation evaluation done)

☐ New job duties/ change in body mechanics (Prior workstation evaluation done)

☐ Return to work after workers' compensation injury

☐ Employee initiated request only (non-Workers' Compensation or industrial accident)

☐ ADA Request

☐ Industrial Accidents working restriction(s): ☐ Yes ☐ No Job Position at time of Evaluation: ☐ Temporary ☐ Permanent
If yes, list the restrictions:_____

Part III: Vision/Hearing

Employee currently: ☐ Does wear glasses ☐ Does not wear glasses for monitor viewing ☐ Does wear hearing aids ☐ Has a teletypewriter or Telecommunications Display Device (TTY/TDD)

Indicate type of glasses: ☐ Single lens ☐ Bifocal ☐ Progressive ☐ Trifocal ☐ Contacts

Part IV: Discomfort Assessment

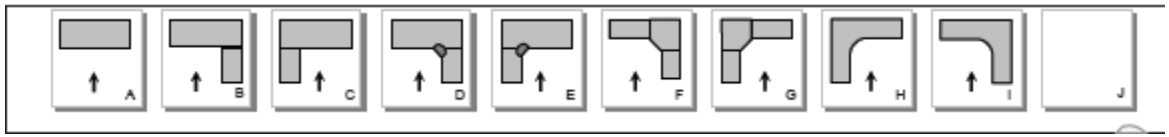
☐ No reported discomfort. ☐ Discomfort associated with routine work task: History of discomfort from:_____ to _____
Date Date

Indicate the location of the discomfort_____

Discomfort level: ☐ Low ☐ Moderate ☐High ***Duration:*** ☐ Occasional ☐ Frequent ☐ Constant

Part V: Workstation Layout

Indicate the desk configuration prior to any change. *Circle configuration most similar.*



Desk type: ☐Free Standing ☐Modular ☐Counter ☐Multi-user

Desk height:_____ inches Monitor height from the workstation: _____inches Monitor size: _____inches Location of mouse:_____

Part VI: Equipment Inventory and Recommendations

Equipment Checklist	Currently Has	Adjustments	Recommendations
Ergonomic Chair with adjustable features to include: ☐High back ☐Armrest ☐Seat tilt (forward) ☐Recline ☐Seat depth adjustable ☐Seat height adjustable ☐Head rest	☐Yes ☐No		
Monitor Size	☐Yes ☐No		
Monitor Arm	☐Yes ☐No		
Monitor Risers	☐Yes ☐No		
Glare Screen	☐Yes ☐No		
Keyboard platform with: ☐ Mouse tray ☐ Without mouse tray ☐Keyboard drawer (non-adjustable)	☐Yes ☐No		
Keyboard Type: _____	☐Yes ☐No		
Keyboard palm support	☐Yes ☐No		

Mouse palm support	☐Yes ☐No		
Floor mat	☐Yes ☐No		
Foot rest	☐Yes ☐No		
Task Lamp	☐Yes ☐No		
Telephone Headset ☐Wireless ☐Corded	☐Yes ☐No		
Electric Stapler (sheet capacity)_____	☐Yes ☐No		
Electric Hole punch ☐2-holes ☐3-holes ☐Both	☐Yes ☐No		
☐Stand-alone Document Holder ☐Attached ☐In-line	☐Yes ☐No		
Other equipment:_____			
Equipment Recommended: ☐Yes ☐No			

Name of Evaluator **Signature** **Date**