Ergonomic Assessment Request Form

Please send the completed and signed form to Nancy.Grijalva@smusd.org

Name:	Location:
Job Title:	Extension:

Reason for requesting assessment:	Medical Note: ☐	General Assessment: ☐	Discomfort: ☐	Workers Comp: ☐

Check all that apply:	Where are you experiencing discomfort:	How severe would you rate your discomfort?
Neck	☐	Slight ☐ Moderate ☐ Severe ☐
Back, Upper	☐	Slight ☐ Moderate ☐ Severe ☐
Back, Lower	☐	Slight ☐ Moderate ☐ Severe ☐
Eyes	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Shoulder	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Upper arm	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Elbow	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Forearm	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Wrist	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Hand	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Hip	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Thigh	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Knee	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Foot	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Other	☐	Slight ☐ Moderate ☐ Severe ☐

Proficient typist: Yes ☐ No ☐	Work computer use: _____ hours per day
Use numeric keypad: Yes ☐ No ☐	Home computer use: _____ hours per day
Corrective lenses: Yes ☐ No ☐	Average phone use: _____ hours per day
Dominant hand: Both ☐ Right ☐ Left ☐	Rest breaks: _____ hours per day

Have you reviewed the Guide to Good Posture at Work?	Yes ☐ No ☐

What adjustments where made after reviewed the Guide to Good Posture at Work? Additional Comments:

Employee Signature: _____