|  |
| --- |
| **Employee Information:**  |
| Employee Name | Personnel Number | Telephone Number | Email Address |
|       |       |       |       |
| Agency | Job Title | Supervisor’s Name |
|       |       |       |
| Physical Address of Work Location |
|       |
| **Instructions:** |
| Please explain the office ergonomics concern related to your workstation. In addition, you may include what you believe may be the cause of the concerns or any other additional information you wish to provide in the comments section below. |
| **Concerns:** |
| Have you ever had an ergonomic evaluation in the past? [ ]  Yes [ ]  No If yes, when? |
| Concern about workstation set-up? [ ]  Yes [ ]  No [ ]  Unsure |
| Concern with physical discomfort? [ ]  Yes [ ]  No [ ]  Unsure |
| Concern with new or revised process, procedure or task? [ ]  Yes [ ]  No [ ]  Unsure |
| Concern with a new workstation or piece of equipment? [ ]  Yes [ ]  No [ ]  Unsure |
| Concern based on medical provider’s recommendations? [ ]  Yes [ ]  No [ ]  Unsure |
| **Comments:** |
| If yes was checked above, please provide comments, or provide additional information about the concern. |
|       |
| Employee Signature | Today’s Date |
|       |       |