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| --- | --- | --- | --- | --- | --- | --- |
| **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 |
|  | | | | | |  |