

Ergonomic Evaluation Request

Please fill out this request online; Print as many copies as you need, send or fax to:
Ergonomics – Organizational Training & Development – Jacobsen Hall Room 417 • Fax (315) 464-4400

Employee Name	Employee's Work Phone Number
Employee's Work Location	Employee's Job Title
Salary Source (Check all that apply): <input type="checkbox"/> State (Hospital) <input type="checkbox"/> State (Campus) <input type="checkbox"/> RF <input type="checkbox"/> MSG <input type="checkbox"/> Other	Department Name:
Supervisor Name	Supervisor's Work Phone Number

Have you had a previous Ergonomic Evaluation? Yes No

Type of Request (Check all that apply):

- Office (VDT) Manual Materials Handling (MMH) Patient Handling Laboratory
 Other

Requested By (Check all that apply):

- Supervisor Employee HR PM&R Employee Health Primary Care Physician PT/OT
 Other

Reason for Request: (Be specific)

Primary Job Duties: (Be specific)

Signature of Employee	Signature of Supervisor
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OFFICE USE ONLY

Request Received By:	Date Received:	Evaluator:
Evaluation Date:	How requestor heard of Ergonomics Program:	
LH	WRIR <input type="checkbox"/> Yes <input type="checkbox"/> No	Class: