Office Ergonomics Evaluation

The Back School

e-mail address

Date	Employee (EE)	Title	Time
DEPARTMENT		Location Cubicle #	MANAGER
EVALUATOR:		PHONE	Injury / Proactive
DESCRIPTION OF WORK PROCESS / Issues reported:			
Photo BEFORE	Photo AFTER	Previous Injury / treatment:	

Hours worked per day: Hands- on comp. time/day: Laptop User? Home computer user? Y / N < > 1hr
Overtime High volume periods ? Details_

Equipment Used	**Yes**	**Brand (if applicable)**	**Type (if applicable)**
Mouse		Right Left CAD Stylus vertical	
Track Ball		Right Left Ambidextrous	
Keyboard		Standard Ergo Split 10 key Y/N	
VDT size = ”		Flat Screen single or dual CRT	% - %
Phone / Headset		Shoulder rest Y/N Wire Cordless	
Stand option		Left Right Fixed manual electric	
Stapler		Standard Ergo ERGO Remover Y / N	
Document Holder		Right Left Center Mounted: desk VDT	
Task light /		Under-count Desk-top Floor	
Pencils / pens / printers		Standard Ergo close / far	
Other			

Visual Inspection	**Yes**	**No**	**Adj**	**If No or if adjusted, explain**
1. Is area free of clutter or obstacles? Top Under	/			
2. Is the Desk adjustable? Wall mounted? YES NO				1° Ht: 2nd area
3. Are there 2 ins. of clearance between thighs & desk?				
4. Are the thighs parallel to the floor & ankles neutral?				
5. Is there 2” between edge of seat and calf w/ rolled pan?				
6. Is the backrest & seat pan adequate for a neutral spine?				
7. Feet flat on floor or using footrest correctly?				Flr. Mat
8. Armrests appropriate & adjusted properly?				
9. Is the job done safely from a sitting position?				
10. Is the keyboard tray – adjustable & in proper position?				
11. Is the keyboard of proper size and shape for worker?				
12. Are appropriate input devices being used?				
13. Is input device the appropriate size & side for hand?				
14. Are wrists neutral/relaxed on keyboard or mouse?				
15. Can shoulders avoid reach/ twist/backward motions?				
16. Is workstation setup for dominant hand? Rt Lt				
17. Are arms at side when keying w/o reaching outwards?				
18. Are sharp edges / contact stress avoided?				
19. Is the 10 key pad used or needed?				
20. Are frequently used tools in primary zone?				
21. Can gripping of thick folders or binders be avoided?				
22. Is the VDT at a comfortable distance? (18-36 inches)				Height

Visual Inspection	Yes	No	Adj	If No or if adjusted, explain
23. Can excessive glare be avoided on VDT or eyes?				
24. If glasses are used, are they appropriate for job?				
25. If bifocals are used, has the VDT been lowered?				
26. Is static neck flexion, rotation or F.H.P. avoided?				
27. When using phone is the neck in neutral position?				
28. Is phone headset needed?				
29. If used, is the document holder in correct position?				
30. Is employee taking regular rest / stretch breaks?				
31. Has there been a recent eye examination?				
32. Is the lighting appropriate and glare free?				
33. Is the work environment free of excessive noise?				
34. Is the work environment temperature appropriate?				

35. OTHER

RECOMMENDED CORRECTIVE ACTION:

EVALUATOR SIGNATURE: DATE

On-file

EMPLOYEE SIGNATURE: DATE

Photographs and Diagram as needed:

send copy of this evaluation to: Employee:☐ Supervisor:☐ Risk Management ☐

CORRECTIVE ACTION SECTION **Person responsible for action:**_____

CORRECTIVE ACTION IMPLEMENTED

1._____

2._____

3._____

4._____

Reason for non-compliance:_____

PRINT Name	**SIGNATURE**	**DATE**