Cal State LA

Ergonomic/Worksite Evaluation Request

Requested by: Employee: _____ Supervisor: _____
Department Administrator: _____ Workers' Compensation: _____
Equity & Diversity: _____

Upon completion, please return form to the Risk Management & Environmental, Health & Safety Office (RM/EHS). The information you submit will be treated confidential to the extent permitted. Please note under the Americans with Disabilities Act or Workers' Compensation cases only your request cannot be processed unless you attach medical documentation (recommending an ergonomic evaluation). For further information regarding ergonomic/worksite evaluations, contact the RM/EHS office @ 3-3531.

Last, First Name: _____ Date of Request: _____

Contact Number: _____ Job Location: _____

Department: _____ Job Title: _____

Immediate Supervisor's Name: _____ Phone Number: _____

Reason(s) for request:

___ I am experiencing discomfort (associated with my workstation)
___ I have a new workstation or I am new to the job
___ I want to ensure my workstation is set up ergonomically correct
___ Other (please specify) _____