REQUEST FOR ERGONOMIC EVALUATION

Supervisor completes this form and submits to:
Human Resources/Risk Management
FAX: 9-526-0101 e-mail: safetyandhealth@sonoma-county.org

Date of request:	Dept/Division:	
Department Ergo Coordinator:		
	Employee	Supervisor
Name:		
Phone:		
E-Mail:		
Building Address:		**Employee Cube/Office #:**
Scheduling comments: (days/times that work well-days off-standing conflicts, etc).		
Current ergonomic concerns / problems / symptoms		
Has employee sought treatment from a medical provider for this ergonomic issue ?		Yes ☐ No ☐
Has a Department level ergonomic evaluation been conducted?		Yes ☐ No ☐
If yes, by whom?	When?	
Ergo Evaluation Attached? Yes ☐ No ☐		
Request submitted by:		

Completed by Vendor

For DM Use Only OCC ☐ NON-OCC ☐
☐ **Please contact DM Analyst Prior to Evaluation**