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Sonoma County
ERGO EVALUATION –OFFICE

EMPLOYEE NAME / PHONE:

DATE:	TIME: EE	TITLE:	DEPARTMENT
LOCATION/ LOCATION TYPE	SUPERVISOR/ PHONE	EVALUATOR	(*SELECT ONE*) ☐ PROACTIVE ☐ INJURY
EE COMPLETED ERGO EDUCATION? Y / N ☐ ☐	DATE OF CLASS	DESCRIPTION OF WORK PROCESS OR ISSUES REPORTED/ SPECIAL ISSUES	

	ERGONOMIC EVALUATION- CHECKLIST	Yes	No
A	Head & Neck upright or in line with the torso (not bent down or back) If no, refer to monitors, chair and work surfaces.	☐	☐
B	Head, neck and trunk to face forward (not twisted). If no refer to monitors or chair.	☐	☐
C	Trunk to be perpendicular to floor (may lean back into back support but not forward) If no refer to chairs or monitors	☐	☐
D	Shoulders and upper arms to be in-line with the torso, generally about perpendicular to the floor and relaxed, not elevated	☐	☐
E	Upper arms and elbows to be close to the body (not extended outward) If no refer to chairs work surface keyboard/pointers	☐	☐
F	Forearms, wrists and hands to be straight and in-line (elbows at 90 degrees) If no refer to chairs keyboards and pointers	☐	☐
G	Wrists & hands to be straight (not bent up/down or deviated) If no refer to keyboards or pointers	☐	☐
H	Thighs to be parallel to the floor and the lower legs to be perpendicular to the floor. If no refer to chairs and work surfaces	☐	☐
I	Feet rest flat on the floor or are supported by stable footrest. If no refer to chairs or work surfaces	☐	☐
J	VDT tasks to be organized to allow EE to vary VDT tasks OR take ERGO breaks while at VDT station	☐	☐
	Comments:		
	SEATING / CHAIR		
1.	Seat width and depth accommodates the specific users needs. Not too big or too small. If no, review chair	☐	☐
2.	Seat front does not press against the back of the knees or lower legs (knees at 90 degrees). If no, review chair	☐	☐
3.	Seat has cushioning and is rounded with a waterfall front, no sharp front edge. If no, review chair	☐	☐
4.	Armrests, one finger width below elbow. Supports both forearms comfortably. If no, review chair	☐	☐
	Comments:		
	KEYBOARD / INPUT DEVICE		
5.	Keyboard/input device platform(s) is stable and large enough to hold both. If no review keyboard tray, pointers or rests	☐	☐
6.	Input device is located immediately next to the keyboard so it can be operated without reaching. If no review keyboards	☐	☐
7.	Input device is easy to activate and the fits hand comfortably. If no review input device options.	☐	☐
8.	Wrists and hands do not rest on sharp or hard edges. If no review rest wrists	☐	☐
	Comments:		
	MONITOR(S)		
9.	Top of the screen is at or below eye level. . If no review monitor or workstation environment	☐	☐
10.	User with bifocals can read the screen without bending the head or neck backwards.	☐	☐
11.	Monitor distance allows user to read the screen without leaning forward or backwards. If no review positions of monitor	☐	☐
12.	Monitor position is directly in front of user to avoid twisting of head or neck. If no, review monitor position	☐	☐
13.	Glare is not reflected on the screen which can cause user to assume awkward position. If no, check monitor	☐	☐
	Comments:		

WORK AREA & ACCESSORIES		
14. Thighs have 2 inches of clearance b/w the top of the thighs & the keyboard tray or work surface. If no, check chair or tray	☐	☐
15. Legs and feet have sufficient clearance space under the work surface to get close to work area.	☐	☐
16. Document holder, if needed is stable and large enough to hold documents without turning head excessively	☐	☐
17. Document holder is front of monitor or at equal distance to monitor or no greater than easy reach to the holder.	☐	☐
18. Wrist/palm rest, is padded with no sharp edges. If not replace with gel or other soft support	☐	☐
19. Wrist/palm rest, allows user to keep forearms, wrists in straight line when using input devices.	☐	☐
20. Telephone can be used without tilting head. If not, consider headset	☐	☐
21. Workstation and equipment sufficiently adjustable to easily make adjustments to chair or trays	☐	☐
22. Computer and other equipment is in proper working order.	☐	☐
23. All reaching above shoulder or behind body has been eliminated	☐	☐
Comments:		

CORRECTIVE ACTIONS TAKEN BY ERGONOMIC EVALUATOR

1.)

2.)

3.)

4.)

5.)

FURTHER CORRECTIVE ACTIONS RECOMMENDED BY EVALUATOR

1.)

2.)

3.)

4.)

5.)

EVALUATOR NAME _____ TITLE _____

EVALUATOR SIGNATURE _____ DATE _____

EMPLOYEE SIGNATURE _____ DATE _____

Sent copy of this evaluation to: Employee:☐ Supervisor:☐ Safety Coordinator ☐

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

CORRECTIVE ACTIONS IMPLEMENTED (INCLUDE DATE). INDICATE REASON FOR ANY DEVIATION FROM RECOMMENDED ACTIONS.

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