Ergonomic assessment request form

Only employees can make evaluation requests.

Employee details		
First and last name		
Email		
Phone		
Department		
Job title		
Supervisor's name		
Supervisor's email		
Duties include		
Computer use — laptop or desktop: How long per week?	Days:	Hours:
Does your job require you to lift objects?	☐ **Yes** ☐ **No**	
If yes to the question above, how often do you lift objects at work?		
How many pounds do you lift?		
Other repetitive tasks		
Please describe any repetitive tasks.		
Are you experiencing pain or other symptoms?	☐ **Yes** ☐ **No**	
If yes to the question above, please describe.		
Preferred days and times for assessment		
Day of the week	☐ **Monday** ☐ **Tuesday** ☐ **Wednesday** ☐ **Thursday** ☐ **Friday**	
Preferred time	☐ **Morning** ☐ **Afternoon**	
Billing contact		
Billing code: Cost center and program group		

Return completed form to Employeehealth@asu.edu
602-496-1917

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