MINNESOTA STATE UNIVERSITY, MANKATO

Work Station Ergonomic Request Form

Send completed and signed form to EHS at WC 111 via hard copy or electronic pdf

The goal of this evaluation is to assess and provide recommendations and/or resources related to an employees work space(s) and possible ergonomic improvements

Name: _____ Phone number: _____

Work location: _____ Email: _____

Department: _____ College: _____

Supervisor: _____ Phone: _____

1. Do you feel your workspace is causing physical/ergonomic discomfort? Y☐ N☐

2. Do you have medical doctor referral(s) regarding ergonomic conditions? Y☐ N☐

3. Do you currently have an ergonomic chair? Y☐ N☐

   If yes, how old is your current chair?_____

   What concerns do you have with your current chair?

   _____

4. What percentage of your workday do you spend sitting?
_____ 0-25%
_____ 25-50%
_____ Over 50%

5. How would you describe the amount of time you spend keystroking/mousing?
_____ Low
_____ Medium
_____ High

Note: Funds are limited, so the following criteria will be followed in determining resource allocation:

- Medical doctor request for ergonomic improvement(s)
- Currently experiencing ergonomic related discomfort related to work station
- Currently has ergonomic equipment (desk, chair etc.) but does not meet needs of employee.

Requestor's Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____