THE University of Vermont HEALTH NETWORK

Champlain Valley Physicians Hospital

Occupational Health & Wellness

Ergonomic Assessment Request

Date:_____

Person requesting Ergonomic Assessment:_____

Department:_____ Extension:_____

Location:_____

Reason for referral?_____

Body part that is being affected? (Please circle) Work days/hours_____

Neck Shoulders Elbows Wrists Hands Back Legs

How long have you been having issues?_____

Are you receiving treatment? YES or NO

Do you work at a desk? YES or NO If yes, is it a shared desk? YES or NO

If yes, how many hours do you sit at your desk in a day?_____

How long have you been at your recent station?_____

_____ _____

Supervisor Date

**Please send this request to Occupational Health & Wellness at EmployeeHealth/COHW@cvph.org
SUBJECT: Ergonomic Evaluation Request