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| --- | --- |
| Date: | |
| To: Maria C. Hernandez Sandoval  Title: Loss Control Manager | | Email: mcsandoval@merma.org | | Phone: (831) 296-9196 | |
| **From:** | **Title:** | | **District:** | | **Phone:** |

**Note: New hire ergonomic evaluations take 30 to 45 minutes. Symptomatic Evaluations take 45 to 60 minutes. Schedule will be sent to District site contact listed in section 1(4)(a)(b) below, to set day and time for the ergo evaluation.**

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| **SECTION 1: District/Agency HR Representative or designee (complete items 1 to 5)** | |
| **1.** | **Employee Information:** |
| a. | **Name: Email: Phone:** |
| b. | **Job Title: Current job hire date: District Hire Date:** |
| c. | **Physical Work Address:**  **Suite/Room No.:**  **City:** |
| d. | Hours Worked: Per day: Per week: More than one location?  Yes  No |
| e. | Prior Ergonomic Evaluation?  Yes  No If yes, when? Ergonomist: |
| f. | **Supervisor Name: Email: Phone:** |
| **2.** | **Reason for Ergonomic Evaluation Request:** |
| a. | New hire  New workstation  Experiencing minor discomfort:  Yes  No  If yes, describe discomfort: |
| b. | Post Injury  Yes  No If post injury, has Intercare been notified?  Yes  No Claim #: |
| **3.** | **Description of current workstation.** |
| a | Select the type of desk that best describes your workstation.      Include a description of all features associated with workstation: |
| **4.** | **District site contact authorized to schedule the date and time of the evaluation.** |
| a. | Name: Title: |
| b. | Email: Phone: |
| **5.** | **Person authorized by the agency to receive the completed report** *(Note: The Ergonomic Evaluation will be sent to person authorized only. Person authorized will disseminate report within their agency.)* |
| a. | Name: Title: |
| b. | Email: Phone: |

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| **SECTION 2: This section reserved for Loss Control Manager - Follow-up and Disposition** |
| Schedule Evaluation: Time: : AM PM Date: / / 20\_\_ |
| Notes: |
| Date report completed: |
| Sent to: |