Date Received_____

Assigned to:_____

Date Assigned:_____

County of San Bernardino
Department of Behavioral Health

ERGONOMIC ASSESSMENT REQUEST FORM

** ONLY A SUPERVISOR MAY COMPLETE THIS FORM

Date of Request: _____

Employee Name: _____

Employee Number: _____

Employee Classification: _____

Employee Department: _____

Employee Work Phone: _____

Office Address: _____

Reason for Request (please describe):_____

_____

Open Worker's Comp Claim? ☐ Yes ☒ No

Employee Work Tasks (please describe):_____

_____

Supervisor's Name: _____

Supervisor's Phone Number: _____

Have you and your supervisor reviewed your workstation with regard to ergonomic guidelines?
http://countyline/riskmanagement/safetycentral/ergonomics.asp

☒ Yes ☐ No

** PLEASE FAX COMPLETED REQUEST FORM TO ERGONOMICS COORDINATOR AT (909) 382-3028