OFFICE ERGONOMIC EVALUATION FORM

Name: _____ Date: _____

Phone: _____ Building / Room Number: _____

Department: _____ Job Title: _____

Departmental Supervisor: _____ Phone: _____

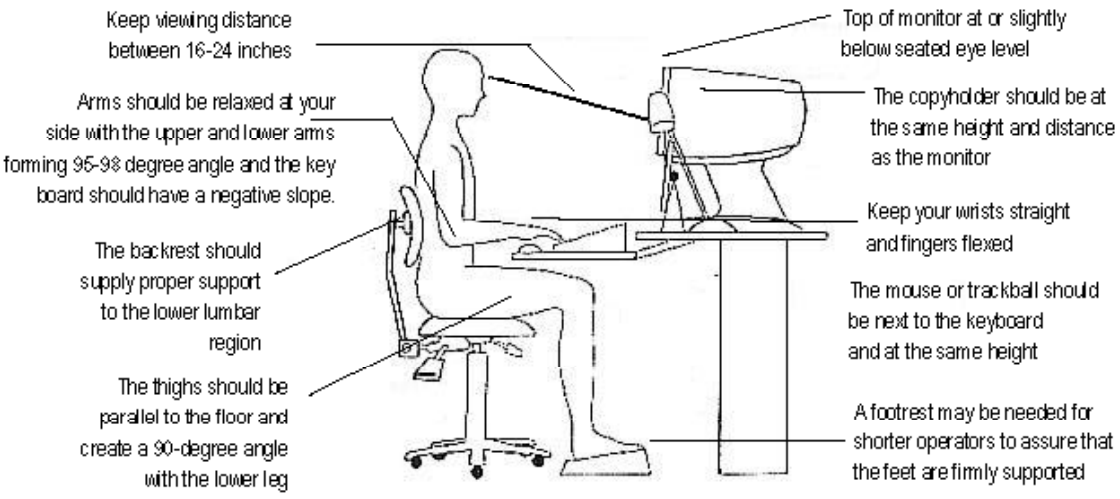
Average Daily PC Usage: ☐ 0-2 Hours ☐ 2-4 Hours ☐ 4-6 Hours ☐ 6+Hours

CTD Symptoms: ☐ Yes ☐ No

Follow-Up: ☐ Yes ☐ No Follow-Up Date: _____

Comments: _____

Correct Sitting Posture



Chair

Feet flat on floor?	☐ Yes	☐ No
Upper legs parallel to floor?	☐ Yes	☐ No
Lower back supported?	☐ Yes	☐ No
Seat pan length OK?	☐ Yes	☐ No

Recommendations

☐ Footrest

☐ Raise chair ☐ Lower chair

☐ Adjust back rest, seat pan, arm rest

☐ Evaluate other chairs

☐ Other