Office of the State Employer

AT-RISK ERGONOMIC ASSESSMENT REQUEST

An At-Risk Ergonomic Assessment requires approval from the Department Designated Appointing Authority Representative along with a medical statement from a licensed physician (D.O. or M.D.) within the last 60 days that includes the physician's printed name, signature, and the request for an ergonomic assessment. The cost of the assessment is paid through the Office of the State Employer (OSE). The Department will determine the appropriate implementation of any suggestions for equipment or workstation adjustments. The At-Risk Ergonomic Assessment Program is not intended to address return-to-work situations, work-related injuries, or Disability Accommodation Requests based on a medical need.

EMPLOYEE INFORMATION		
EMPLOYEE NAME	**EMPLOYEE ID #**	**DEPARTMENT/AGENCY**
WORK ADDRESS	**JOB TITLE/OCCUPATION**	**UNION/EMPLOYEE GROUP**
COUNTY	**WORK ☎**	**EMAIL ADDRESS**
SUPERVISOR NAME	**SUPERVISOR ☎**	**SUPERVISOR EMAIL ADDRESS**

ACKNOWLEDGMENT & AUTHORIZATION TO RELEASE INFORMATION

- **I understand an At-Risk Ergonomic Assessment may not result in new equipment, office supplies, or work surface adjustments, and that my Department will determine the appropriate implementation of any suggestions for equipment or workstation adjustments.**
- My signature below authorizes the Department Designated Appointing Authority Representative, the OSE, CMI, A York Risk Services Company or any other necessary party to discuss my request or share the accompanying medical referral for the purpose of addressing my At-Risk Ergonomic Assessment.

Employee Signature _____ Date _____

DEPARTMENT DESIGNATED APPOINTING AUTHORITY REPRESENTATIVE INFORMATION AND APPROVAL

CONTACT NAME	**EMAIL ADDRESS**	**WORK ☎**
HAVE INTERNAL ERGONOMIC PROCEDURES BEEN EXHAUSTED? ☐ Yes ☐ No	***Left Blank Intentionally***	

*****DISCUSS ROUTINE DUTIES AND PERCENT (%) VALUE WITH SUPERVISOR; TIME MAY NOT EQUAL 100%***** **IN A TYPICAL WORKWEEK, HOW MUCH TIME DOES THE EMPLOYEE SPEND DOING THE FOLLOWING:**

☐ Attending Meetings _____
☐ Bending & Stooping _____
☐ Climbing _____
☐ Kneeling, & Squatting _____
☐ Dispensing Liquids _____
☐ Driving *(not daily commute)* _____
☐ Filing _____
☐ Grasping _____
☐ Standing _____
☐ Lifting & Carrying
  ☐ 0-10 lbs. _____
  ☐ 10+ lbs. _____
☐ Pipetting _____
☐ Pushing & Pulling
☐ Reaching _____
☐ Reading _____
☐ Sitting _____
☐ Other: _____
☐ Stapling _____
☐ Twisting _____
☐ Typing/Keying _____
☐ Using a Microscope _____ (Micromanipulation & Dissection)
☐ Using the Telephone _____
☐ Walking _____
☐ Writing _____

OTHER INFORMATION EVALUATOR SHOULD BE MADE AWARE OF

REQUESTED SERVICE

☐ Work Station Assessment ☐ Other (e.g., Lab, Mailroom, Vehicle, etc.):

Department Designated Appointing Authority Representative Signature _____ Date _____