Office of the State Employer

AT-RISK ERGONOMIC ASSESSMENT REQUEST

An At-Risk Ergonomic Assessment requires approval from the <u>Department Designated Appointing Authority Representative</u> 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 <u>Disability Accommodation Requests</u> based on a medical need.

EMPLOYEE NAME EMPLOYEE ID # DEPARTMENT/AGENCY WORK ADDRESS JOB TITLE/OCCUPATION UNION/EMPLOYEE GROUP COUNTY WORK 2 EMAIL ADDRESS SUPERVISOR NAME SUPERVISOR 2 SUPERVISOR EMAIL ADDRESS ACKNOWLEDGMENT & AUTHORIZATION TO RELEASE INFORMATION ACKNOWLEDGMENT & AUTHORIZATION TO RELEASE INFORMATION I understand an AI-Risk Ergonomic Assessment may not result in new equipment, office supplies, or work surface adjustments, and that my Department the appropriate implementation of any suggestions for equipment or workstation adjustments. M y 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 INFORMATION			
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Department Designated Appointing Authority Representative Signature Date	Work Station Assessment Other (e.g., Lab, Mailroom, Vehicle, etc.):			
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