



Sonoma County ERGO EVALUATION -OFFICE

EMPLOYEE NAME / PHONE:

DATE:	TIME:	EE TITLE:	DEPARTMENT
LOCATION/ LOCATION TYPE		SUPERVISOR/ PHONE	EVALUATOR
			(CIRCLE ONE) PROACTIVE INJURY
EE COMPLETED ERGO EDUCATION? Y / N	DATE OF CLASS	DESCRIPTION OF WORK PROCESS OR ISSUES REPORTED/ SPECIAL ISSUES	

ERGONOMIC EVALUATION- CHECKLIST		Yes	No
A.	Head & Neck upright or in line with the torso (not bent down or back) If no, refer to monitors, chair and work surfaces.		
B.	Head, neck and trunk to face forward (not twisted). If no refer to monitors or chair.		
C.	Trunk to be perpendicular to floor (may lean back into back support but not forward) If no refer to chairs or monitors		
D.	Shoulders and upper arms to be in-line with the torso, generally about perpendicular to the floor and relaxed, not elevated		
E.	Upper arms and elbows to be close to the body (not extended outward) If no refer to chairs work surface keyboard/pointers		
F.	Forearms, wrists and hands to be straight and in-line (elbows at 90 degrees) If no refer to chairs keyboards and pointers		
G.	Wrists & hands to be straight (not bent up/down or deviated) If no refer to keyboards or pointers		
H.	Thighs to be parallel to the floor and the lower legs to be perpendicular to the floor. If no refer to chairs and work surfaces		
I.	Feet rest flat on the floor or are supported by stable footrest. If no refer to chairs or work surfaces		
J.	VDT tasks to be organized to allow EE to vary VDT tasks OR take ERGO breaks while at VDT station		
Comments:			
SEATING / CHAIR			
1.	Seat width and depth accommodates the specific users needs. Not too big or too small. If no, review chair		
2.	Seat front does not press against the back of the knees or lower legs (knees at 90 degrees). If no, review chair		
3.	Seat has cushioning and is rounded with a waterfall front, no sharp front edge. If no, review chair		
4.	Armrests, one finger width below elbow. Supports both forearms comfortably. If no, review chair		
Comments:			
KEYBOARD / INPUT DEVICE			
5.	Keyboard/input device platform(s) is stable and large enough to hold both. If no review keyboard tray, pointers or rests		
6.	Input device is located immediately next to the keyboard so it can be operated without reaching. If no review keyboards		
7.	Input device is easy to activate and the fits hand comfortably. If no review input device options.		
8.	Wrists and hands do not rest on sharp or hard edges. If no review rest wrists		
Comments:			
MONITOR(S)			
9.	Top of the screen is at or below eye level. . If no review monitor or workstation environment		
10.	User with bifocals can read the screen without bending the head or neck backwards.		
11.	Monitor distance allows user to read the screen without leaning forward or backwards. If no review positions of monitor		
12.	Monitor position is directly in front of user to avoid twisting of head or neck. If no, review monitor position		
13.	Glare is not reflected on the screen which can cause user to assume awkward position. If no, check monitor		
Comments:			

ERGONOMIC EVALUATION- CHECKLIST		Yes	No
WORK AREA & ACCESSORIES			
14.	Thighs have 2 inches of clearance b/w the top of the thighs & the keyboard tray or work surface. If no, check chair or tray		
15.	Legs and feet have sufficient clearance space under the work surface to get close to work area.		
16.	Document holder, if needed is stable and large enough to hold documents without turning head excessively		
17.	Document holder is front of monitor or at equal distance to monitor or no greater than easy reach to the holder.		
18.	Wrist/palm rest, is padded with no sharp edges. If not replace with gel or other soft support		
19.	Wrist/palm rest, allows user to keep forearms, wrists in straight line when using input devices.		
20.	Telephone can be used without tilting head. If not, consider headset		
21.	Workstation and equipment sufficiently adjustable to easily make adjustments to chair or trays		
22.	Computer and other equipment is in proper working order.		
23.	All reaching above shoulder or behind body has been eliminated		
Comments:			

CORRECTIVE ACTIONS TAKEN BY ERGONOMIC EVALUATOR

1.)

2.)

3.)

4.)

5.)

FURTHER CORRECTIVE ACTIONS RECOMMENDED BY EVALUATOR

1.)

2.)

3.)

4.)

5.)

 EVALUATOR NAME TITLE EMPLOYEE NAME TITLE

 EVALUATOR SIGNATURE DATE EMPLOYEE SIGNATURE DATE

Sent copy of this evaluation to: Employee: Supervisor: Safety Coordinator

CORRECTIVE ACTION TAKEN Person responsible for action: _____

CORRECTIVE ACTIONS IMPLEMENTED (INCLUDE DATE). INDICATE REASON FOR ANY DEVIATION FROM RECOMMENDED ACTIONS.

 PRINT Name SIGNATURE DATE