Appendix 2
Office Ergonomics Hazard Identification Report

CONTRACT/ REFERENCE NUMBER	EMPLOYEE NAME, LOCATION, OFFICE AND TELEPHONE NUMBER	MANAGER NAME AND TELEPHONE NUMBER
ASSESSMENT DATE Day/Month/Year	**TIME AND DURATION OF ASSESSMENT**	**DEPARTMENT/AGENCY/ CROWN CORPORATION**
Consultant	**Company Name**	**Telephone Number**

1. Reason for the assessment – What are the ergonomic related need(s) or hazard(s) as described by the employee and/or manager?

2. Job title:	**What are the requirements of the job/work activities/organization of work and method in which the work activities are performed?**

3. What are the characteristics of the employee's immediate workstation associated to the employee's work? (Add a picture or sketch as an appendix, if needed)

4. What are the characteristics of the employee including the data? (Please complete Appendix 1)		
Height:	**Corrective Lenses:**	**Hand dominance:** **Mouse use:**

5. What are the specific hazards the employee is exposed to and the effect to his/her health and safety; and how will the hazards be eliminated, reduced or protected against? (Refer to Appendix 1, attached)

Describe the features of the tools/equipment currently being used that are causing a hazard or potential hazard.	Based on duration and frequency, what is the employee's exposure(s) to the hazard(s)?	Describe the real or potential effect of the exposure (i.e. discomfort, pain, etc.).	List adjustments made during the assessment.	Describe recommendations to be implemented and/or characteristics of equipment recommended to be provided.
Chair				
Keyboard Tray				
Keyboard				
Palm Rest				
Pointing Device				
Monitor				
Desk/Work Surface				

Telephone (Distance, frequency of use)				
Desktop/laptop/other (Access to USB/CD drive, location)				
Footrest				
Document Holder				
Lighting				
Work Habits (Use of break, work organization, posture, etc.)				
Other				

6. If applicable, provide photos or sketches of pre and post adjustments.
7. Summary of education/recommendations provided to the employee.
8. Is there any other additional one-on-one training or education required that was not provided during this assessment?
9. Is a follow-up ergonomic assessment required?
10. Signatures
Consultant: ______________________________ Date:______________________
For internal use only
Manager: ______________________________ Date:______________________
Employee: ______________________________ Date: ______________________