County of Alameda  
Risk Management Unit  

Request for Ergonomic Evaluation  

This form is to be completed by an Employee, Supervisor, or Agency/Department Safety Coordinator. It requires the signature of the Supervisor and the Agency/Department Safety Coordinator before an ergonomic evaluation can be scheduled.  

Employee/Workunit Name: _______________________________  Date: ___________  

If a Work Unit is to be evaluated, # of employees: _______  
(Please attach a list of employees’ names, worker #, phone, and QIC)  

Agency/Dept.: _______________________________  Email: _______________  

Organization #: ___________  Fund#: ___________  Acct#: ___________  Prgm: ___________  

Address: _______________________________  Floor/ Room /Suite #: _______  

Phone: _______________  Wkr.#: _______________  QIC: _______  

Reason for this request:  
☐ Prevention  ☐ Discomfort/Pain  Where: ___________  
☐ Relocation/new workstation  ☐ Other: _______________  
☐ Doctor’s order (please attach document)  

Previous evaluation done?  No ☐  Yes ☐ (Prevention ☐  OR  Workers’ Comp ☐)  

If YES:  Date of prior evaluation: _______  Where: _______________________________  
Reason for second evaluation: _______________________________  

If an individual, is there an open or closed workers’ compensation case?  Yes ☐  No ☐  

If YES:  Date of injury: _______  

Supervisor: _______________  E-mail: _______________  QIC: ___________  
(Please print)  

Signature: _______________  Phone: _______________  

Agency/Department Safety Coordinator: _______________  Phone: _______________  
(Please print)  

Agency/Department Safety Coordinator Signature: _______________  Date: ___________  

After Supervisor and Agency Health & Safety Coordinator have signed, this form is sent to:  

ErgoLab (ergolab@acgov.org)  Phone: 510-272-(2)6498  Fax: 510-272-(2)6815  QIC: 28505  

AgencyDept Ergo Eval Req Form 12.05