Ontario-Montclair School District

Ergonomic Evaluation Request

Please fill out form and submit to:

Risk Management Department @ risk.mgmt@omsd.net

EMPLOYEE INFORMATION:

Date: _____

Employee Name: _____

Site/ Dept. Name: _____ Classroom #: _____

Job Title: _____ Work Hours: _____ to _____

Phone #: _____ Email Address: _____

Reason for Request: _____

_____

_____

DR. NOTE REQUIRED FOR SIT/STAND DESK ACCOMMODATIONS
or MEDICAL CONDITION REQUIRING SPECIFIC ACCOMMODATIONS

SUPERVISOR INFORMATION:

By signing this request, I acknowledge that I have reviewed the information above and that specific ergonomic equipment recommendations will need to be purchased by my department/site and not Risk Management.

Supervisor Name: _____

Supervisor Signature: _____

For Risk Management Staff Use Only:

Date Received: _____ Date Evaluation Completed: _____