**REQUEST ERGONOMIC ASSESSMENT FORM**

If you request an ergonomic assessment, you must complete the information as requested below. If you are located at HQ, submit the form to your Director for approval. For all other locations, submit the form to the Senior Local Employer Representative (SLER) of your division for approval.

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| **To Be Completed by the Employee** | | | | | | | | |
| Employee Name |  | | | Employee number | | |  | |
| Email address |  | | | Phone Number | | |  | |
| Job Title |  | | | Division | |  | | |
| How long have you held this occupation | | (in years) | | First Official Language | | | | E /  F |
| Have you referred to the ergonomics guide? | | Y /  N | | Language of Correspondence | | | | E /  F |
| Brief description of pain *(no detailed medical information please)* | | | | | | | | |
| Is the pain from a work related injury?  Y /  N | | | | If “YES” please provide date: | | | | |
| If “YES”, number of restricted work days *(light duties)* as a result of this injury | | | | | | | | |
| If “YES”, number of lost days as a result of this injury | | | | | | | | |
| Do you feel your condition requires an urgent assessment:  Y /  N | | | | | Do you have a medical certificate?  Y /  N | | | |
| Supervisor's name: | | | | Have you informed your supervisor?  Y /  N  Y /  N | | | | |
| **I understand that once my appointment with an Ergonomic Consultant has been booked, it is my responsibility to provide at least 24 hours notice to the consultant and by e-mail to the Local Human Resources Office should I require it to be rescheduled. I understand that a no-show or a rescheduling with less than 24 hours notice may result in the cost for my missed appointment being charged to employer unnecessarily.** | | | | | | | | |
| Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: \_\_\_\_\_\_\_\_\_ | | | | | |
| **Once your request is approved, you will be contacted by the service provider within 3 weeks to arrange an appointment. If you have not been contacted by the service provider within 3 weeks of submitting your request, please contact the Local HR Office to inquire on the status. Similarly, if you do not receive an electronic copy of your ergonomic report within 4 weeks of the visit by the Ergonomic Consultant, please contact Local HR Office for an update on the status of your report.** | | | | | | | | |

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| **To be completed by the Approver**  If you are located at HQ, submit the form to your Director for approval. For all other locations, submit the form to the Senior Local Employer Representative (SLER) of your division | | | |
| **Please note that all fees, assessments and equipment, are to be paid by your division. The Local HR Office will provide you with the invoice as well as the consultant report for action. You are responsible to take action in a timely manner.** | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Director Name (if located at HQ) **or** SLER Name (Other location) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Director/SLER Signature | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GL # | \_\_\_\_\_\_\_\_\_  Date |

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| **To be completed by the Local HR Office** | | |
| Name of Ergonomic Consultant |  | |
| Confirmation of Appointment | Date: | Approximate time: |
| \_\_\_\_\_\_\_\_\_\_\_  Date HR received the Ergonomic Assessment Report | \_\_\_\_\_\_\_\_\_\_\_  Date the Supervisor received the Ergonomic Assessment Report | \_\_\_\_\_\_\_\_\_\_\_  Date the Employee received the Ergonomic Assessment Report |
| Notes: (1) File completed form in employee personal file  (2) Forward ergonomic consultant invoice to the approver listed above for payment. | | |