

### INDUSTRIAL ERGONOMICS ASSESSMENT SURVEY

<b>Employee Name:</b>	<b>Date:</b>
<b>Job Title:</b>	<b>Dept.:</b>
<b>Extension:</b>	<b>Yrs. at Position:</b>
<b>Right / Left Handed</b>	<b>Employee Height:</b> ft.                  inches

**Job Description:**

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**Other Jobs Assigned During the Day:**

**Breaks – Time /**                  **Morning** \_\_\_\_\_                  **Lunch** \_\_\_\_\_                  **Afternoon** \_\_\_\_\_

**Evaluator Name:** \_\_\_\_\_                  **Extension:** \_\_\_\_\_

**Daily Use, Equipment #1** \_\_\_\_\_:                   N / A

2 hours or less per day     2 to 4 hours per day     >5 hours per day

**Hazards of Equipment**  Heat     Vibration     Weight     Other

**Daily Use, Equipment #2** \_\_\_\_\_:

2 hours or less per day     2 to 4 hours per day     >5 hours per day

**Hazards of Equipment**  Heat     Vibration     Weight     Other

**Daily Use, Equipment #3** \_\_\_\_\_:

2 hours or less per day     2 to 4 hours per day     >5 hours per day

**Hazards of Equipment**  Heat     Vibration     Weight     Other

**Material Handling – Duties / Tasks:**

**Tasks Require Manual Lifting**                   **Equipment Assisted Lifting**

**Frequency Of Lift:**

> 15#                   < 5-10 times daily     < 11-20 times     >21 times

>25#                   < 5-10 times daily     < 11-20 times     >21 times

> 45#                   < 5-10 times daily     < 11-20 times     >21 times

**Proper Lifting Techniques:**

**Does Employee Understand and Practice Proper Lifting Methods?**  YES  NO

**HAZARD EVALUATION/IDENTIFICATION:**

<input type="checkbox"/> Temperature Cold / Heat	<input type="checkbox"/> Rep. Carrying	<input type="checkbox"/> Push / Pull
<input type="checkbox"/> Heavy Weight	<input type="checkbox"/> Position / Posture	<input type="checkbox"/> Vibration
<input type="checkbox"/> Excessive Reaching	<input type="checkbox"/> Tactile	<input type="checkbox"/> Rotation
<input type="checkbox"/> Excessive Stretching	<input type="checkbox"/> Grip	<input type="checkbox"/> Twisting
	<input type="checkbox"/> Excessive Noise	

**SITTING / STANDING / STOOPING / BENDING / WALKING / RUNNING: EXCESSIVE -**

<b>Sitting:</b> <input type="checkbox"/> Less than 1 hr. daily <input type="checkbox"/> More than 3-5 hrs. daily <input type="checkbox"/> More than 5 hrs. daily	<b>Bending:</b> <input type="checkbox"/> Less than 1 hr. daily <input type="checkbox"/> More than 3-5 hrs. daily <input type="checkbox"/> More than 5 hrs. daily
<b>Standing:</b> <input type="checkbox"/> Less than 1 hr. daily <input type="checkbox"/> More than 3-5 hrs. daily <input type="checkbox"/> More than 5 hrs. daily	<b>Walking:</b> <input type="checkbox"/> Less than 1 hr. daily <input type="checkbox"/> More than 3-5 hrs. daily <input type="checkbox"/> More than 5 hrs. daily
<b>Stooping:</b> <input type="checkbox"/> Less than 1 hr. daily <input type="checkbox"/> More than 3-5 hrs. daily <input type="checkbox"/> More than 5 hrs. daily	<b>Running:</b> <input type="checkbox"/> Less than 1 hr. daily <input type="checkbox"/> More than 3-5 hrs. daily <input type="checkbox"/> More than 5 hrs. daily

**EQUIPMENT THAT ASSISTS YOU MOST:**

**EQUIPMENT YOU WOULD LIKE TO USE:**

**EMPLOYEE COMMENTS:**

**Describe Your Greatest Work Concerns / Issues:**

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**EMPLOYEE SIGNATURE**

**DATE:**

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