



## In-Office Ergonomic Evaluation Request Form

Please complete and submit this form to [mybenefits@fhda.edu](mailto:mybenefits@fhda.edu)

**REQUESTOR**

Date

Employee CWID

Department

First Name:

Last Name:

Phone:

Email:

Campus:

 Foothill /Sunnyvale    De Anza    District

Job Title:

Address/Physical Location:

*Floor/Suite Number / Room Number*

**REASON FOR AND TYPE OF REQUEST:**

Office

Multi-User

Other

*Please list specific issues prompting your request for an evaluation.  
Do NOT document any protected health information.*

Do you have a current workers' compensation claim for a repetitive motion or cumulative trauma injury, or, an injury or condition?

Yes

No

**Important Note:** The District does not arrange ergonomic evaluations for at-home work stations. The employee's Department is responsible for the purchase of any in-office workstation items and/or equipment that may be recommended by consultant, subject to reasonable accommodation and supervisor approval.

**SUPERVISOR APPROVAL**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone#: \_\_\_\_\_ Email: \_\_\_\_\_