



ERGONOMIC VDT WORKSTATION EVALUATION

If you feel that you have sustained a work-related injury it important that you report the injury to your manager or supervisor. To find out more about the campus' Workers' Compensation program please visit the University Risk Management Website at <http://www.csupomona.edu/~rms/wc.htm> or call extension 3725.

Part 1: Employee Information

Name:	Dept:	Job Title:
Hand Dominance: <input type="checkbox"/> Right <input type="checkbox"/> Left	Weight Range: <input type="checkbox"/> under 250 lbs <input type="checkbox"/> 250 - 300 lbs <input type="checkbox"/> over 300 lbs	Supervisor:
Height: ____ Feet ____ Inches		Telephone:

Part 2: Personal and Injury History

☒ ☒ Check each item or write N/A if not applicable

		Yes/No	Comments or Recommendations
Medical History (If "yes" to injury, complete rest of section)	Do you have any current injuries or pain/discomfort?	<input type="checkbox"/>	
	Have you filed a Workers' Comp claim with the job?	<input type="checkbox"/>	
	Do you have any previous history of these injuries?	<input type="checkbox"/>	
	Are you aware of any other contributing factors to your injuries?	<input type="checkbox"/>	
	Were these previous injuries due to work related events?	<input type="checkbox"/>	
	Do you have any off work activities?	<input type="checkbox"/>	
	After work, with rest, do you still feel discomfort?	<input type="checkbox"/>	
	Do you feel better on weekends with rest?	<input type="checkbox"/>	
	Has the discomfort limited any non-occupational activities?	<input type="checkbox"/>	
Has the discomfort limited any of your work activities?	<input type="checkbox"/>		
Injury History	If you are feeling discomfort, where is it located? What movements specifically cause discomfort? How long has the discomfort lasted (days, months, etc.)? What event caused the initial onset of your condition? What has your physician diagnosed as the cause? What treatments have been prescribed for the injury? Does this treatment affect your work tasks? When is your next scheduled visit with your physician?	COMMENTS	

Part 3: Job Tasks

Sitting: ____ % Standing: ____ %	Computer Use: ____ % Phone Use: ____ % Writing: ____ % Reading: ____ %
Walking: ____ %	Copying, Sorting, Filing: ____ % Other: ____ %

Part 4: Workstation Equipment

☒ ☒ Check each item or write N/A if not applicable

		Yes/No	Comments or Recommendations
Work Surface Area	Height Adjustable?	<input type="checkbox"/>	
	Adequate Height & Space for Reading/Writing Tasks?	<input type="checkbox"/>	
	Minimal Reaching Above Shoulder Level?	<input type="checkbox"/>	
	Commonly Used Items in Close Proximity?	<input type="checkbox"/>	
	Adequate Space for Easy Access to Binders, Files, etc.?	<input type="checkbox"/>	
	Calculator & Other Equipment Arranged for Neutral Postures?	<input type="checkbox"/>	
Chair/Stool	Swivel Seat and 5 Point Base with Casters?	<input type="checkbox"/>	
	Seat Height Adjustable 16"-21"?	<input type="checkbox"/>	
	Seat Height Allows for Approximate 90° Bend at Knees/Hips?	<input type="checkbox"/>	
	Adequate Leg/Foot Clearance?	<input type="checkbox"/>	

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Chair/Stool Continued	Feet Flat on Floor or Supported When Seated? Backrest Height Set to Provide Lumbar Support Adjustable Backrest Tilt 10° -15°? Backrest & Seat Supportive and Fits Properly? Armrest Height Allows for Approximate 90° Bend at Elbows? Is the chair fully adjustable for user? Forearms Parallel to Floor?	☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐	
Monitor	Centered to User? Top of Screen at or Slightly Below Eye Level? Does Employee Wear Bifocals? If Yes, Lower Monitor Position. Viewing Distance 12"-18"? Adjustable Swivel/Tilt?	☐☐ ☐☐ ☐☐ ☐☐ ☐☐	
Keyboard	Centered to User? Adjustable Keyboard (Height/Slope)? Are user's wrists straight as possible? Elbows Close to Body & Bent at 90°? Wrist Rest Used?	☐☐ ☐☐ ☐☐ ☐☐ ☐☐	
Mouse	If Used: Placed Level/Adjacent to Keyboard? Mouse Tray Required?	☐☐ ☐☐	
Copy Holder	If Used: Located at Eye Level? Adjustable Height, Distance & Angle? Adequate Space to Position?	☐☐ ☐☐ ☐☐	
Phone	Within Easy Reach? Neutral Neck Posture Maintained? Headset Used?	☐☐ ☐☐ ☐☐	
Lighting	Adequate Lighting Provided (20 - 50 Foot Candles)? Glare on Screen? If Yes, source: _____ Clean Screen? Adjustable Task Light(s) Used?	☐☐ ☐☐ ☐☐ ☐☐	
Equipment Noise	Noise Level Makes it Difficult to Carry on Conversation? If Yes, source: _____	☐☐	

Part 5: Additional Comments/Recommendations *☞ Check all applicable items*

Workstation Adjustments	Description of Proposed Changes
<input type="checkbox"/> Rearrange Furniture/Equipment	
<input type="checkbox"/> Adjust Chair for Neutral Posture	
<input type="checkbox"/> Lower <input type="checkbox"/> Raise Work Surface	
<input type="checkbox"/> Lower <input type="checkbox"/> Raise Monitor	
<input type="checkbox"/> Center Monitor to User	
<input type="checkbox"/> Reposition Monitor to Reduce Glare	
<input type="checkbox"/> Lower <input type="checkbox"/> Raise Keyboard	
<input type="checkbox"/> Center Keyboard to User	
<input type="checkbox"/> Adjust Keyboard Angle	
<input type="checkbox"/> Reposition Mouse/Phone/Calculator/Binders/Files	
<input type="checkbox"/> Use Tilted Work Surface	
<input type="checkbox"/> Other	

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Equipment/Ergonomic Accessories	Description of Proposed Changes
<input type="checkbox"/> Anti Glare Screen	
<input type="checkbox"/> Back Cushion/Support	
<input type="checkbox"/> Chair	
<input type="checkbox"/> Copyholder	
<input type="checkbox"/> Footrest	
<input type="checkbox"/> Keyboard Tray/Drawer	
<input type="checkbox"/> Monitor Riser/Stand	
<input type="checkbox"/> Mouse Tray	
<input type="checkbox"/> Mouse	
<input type="checkbox"/> Headset/Phone Cradle	
<input type="checkbox"/> Slant board/Tilted Work Surface	
<input type="checkbox"/> Task Light	
<input type="checkbox"/> Wrist Rest	
<input type="checkbox"/> Writing Grips	
<input type="checkbox"/> Other	
Work Process Changes	Description of Proposed Changes
<input type="checkbox"/> Alter Work Methods (Work in "Neutral")	
<input type="checkbox"/> Encourage Frequent Posture Changes/Rest Pauses	
<input type="checkbox"/> Provide Training/Instruction	
<input type="checkbox"/> Other	

Comments:

Evaluated by: _____

Date of Evaluation: _____