ERGO LIFE SOLUTIONS
~Wellness in the Workplace

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Ergonomic Request Form

Date Requested:_____

Employee To Be Evaluated: _____Job Title:_____

Employee Phone Number:(____)_____-_____ E-Mail Address:_____

Business Name:_____Department:_____

Street address:_____ Location (room/cubicle)_____

Supervisor: _____ Phone Number: (____)_____-_____
(Please print legibly)

Supervisor Job Title:_____ E-Mail Address:_____

Supervisor Signature:_____ Date:_____

Reason for Request: _____

_____

_____

_____

Is this request related to a CURRENT Worker's Compensation Claim?: Yes_____ No _____

Date of Claim:_____ Physician:_____ Telephone:_____

If you checked "Yes", please provide contact information for your Worker's Compensation analyst:

Name:_____ Email:_____ Telephone:_____