Exhibit

E 4157.2
PERSONNEL

ERGONOMICS

Ergonomic Assessment Request Form

Please send the completed and signed form to ergonomics@stocktonusd.net.

Name:	Employee ID:
Job Title:	Department:
Phone Number/Extension:	Email Address:

Please provide reason for requesting an Ergonomic Assessment:

☐ **Medical Note** ☐ **General Assessment** ☐ **Discomfort** ☐ **Workers Compensation**

SELF ASSESSMENT CHECKLIST (To be completed by employee):

Check all that apply:	Where are you experiencing discomfort?	How severe would you rate your discomfort?
Neck	☐	Slight ☐ Moderate ☐ Severe ☐
Back, Upper	☐	Slight ☐ Moderate ☐ Severe ☐
Back, Lower	☐	Slight ☐ Moderate ☐ Severe ☐
Eyes	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Shoulder	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Upper arm	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Elbow	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Forearm	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Wrist	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Hand	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Hip	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Thigh	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Knee	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Foot	Left ☐ Right ☐	Slight ☐ Moderate ☐ Severe ☐
Other: _____ (Please specify)	☐	Slight ☐ Moderate ☐ Severe ☐

Proficient typist:	Yes ☐ No ☐
Use numeric keypad:	Yes ☐ No ☐
Corrective lenses:	Yes ☐ No ☐
Dominant hand:	Both ☐ Right ☐ Left ☐
Work computer use:	_____ hours per day
Home computer use:	_____ hours per day
Average phone use:	_____ hours per day
Rest breaks:	_____ hours per day

Additional Comments:

Employee Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____