ERGONOMIC WORKSTATION REQUEST

This form may assist you in requesting and ergonomic workstation to the right department depending on the reason of the request.

SECTION I – EMPLOYEE INFORMATION		Date of Request:	
Last Name:		First Name:	
Phone Number:		Job Title:	
Email:		Department:	
YC Number:		Supervisor Name:	

SECTION II – REQUEST INFORMATION	
Did your healthcare provider recommended an evaluation of your workstation due to pain or numbness, a work injury, non-work injury or disability?	
○ Yes	○ No
***If your answer to the question above was **YES**, you need to return the form to your HR Business Partner to provide additional documentation to approve the request per the Americans with Disabilities Act (ADA). Accommodations under ADA will be covered under HR budget. If your answer is **NO**, you will return the form to your manager to proceed with the request. A work order needs to be created after approval by your manager; an any expense will be assumed by the Employee's department.	
Please, briefly explain what you are requesting to be upgraded/changed?	

SECTION III – ACKNOWLEDGEMENT & SIGNATURE	
Employee signature:	Date:
Supervisor Signature:	Date: