McMaster University

Faculty of Health Sciences

Office Ergonomics Self Assessment

(This form must be completed before appointments can be booked)

Name:	Department:	Date:
Email:	Position:	Bldg/Rm#:
Phone Ext:	Supervisor:	Have you completed Ergonomics training via Mosaic? ☐Yes ☐No **Ergonomics training is mandatory for all staff.*
Typical work hours per day: Hrs. Total break time per day: Mins.		

Typical Duties	**Time per day**	**Provide comments**
Computer Work		
Paperwork		
Meetings		
Filing / Sorting		
Telephone		
Photocopying		
Other (specify)		

Please indicate the percent of time spent using the following computer input methods each day:
Mouse: %
Letter Keys: %
Number keys(Pad): %
Secondary Functions (i.e. F2, Tab): %

What percentage of the day involves interacting with the computer independently (i.e. email)? %
How often do you combine computer work with reading paper work (i.e. transcribing, researching? %
How often do you combine computer work with writing paper work (i.e. editing paperwork)? %
What percentage of the day involves using telephones while writing messages or using the computer? %

What software do you use most frequently (i.e. Peoplesoft, email etc.)?

Do you use a laptop for work? ☐Yes ☐No
What kind of carrying case do you transport the laptop? ☐Roller Case ☐Single shoulder strap ☐Backpack

How long do you typically sit at your workstation at one time without standing? mins./hrs.

Visual Information:
Corrective lenses: ☐None ☐Single lens glasses ☐Bi/ Tri-focals/ Progressive ☐Contact Lenses
If you wear bi /tri-focals what part of the lens do you look through?
i) To view the computer screen? ☐Bottom ☐Middle ☐Top ☐N/A
ii) To read paper documents? ☐Bottom ☐Middle ☐Top ☐N/A
iii) When speaking with people? ☐Bottom ☐Middle ☐Top ☐N/A

McMaster University

Faculty of Health Sciences

Using the following pictures please circle the area(s) in which you currently experience symptoms (if any) while performing your work tasks.

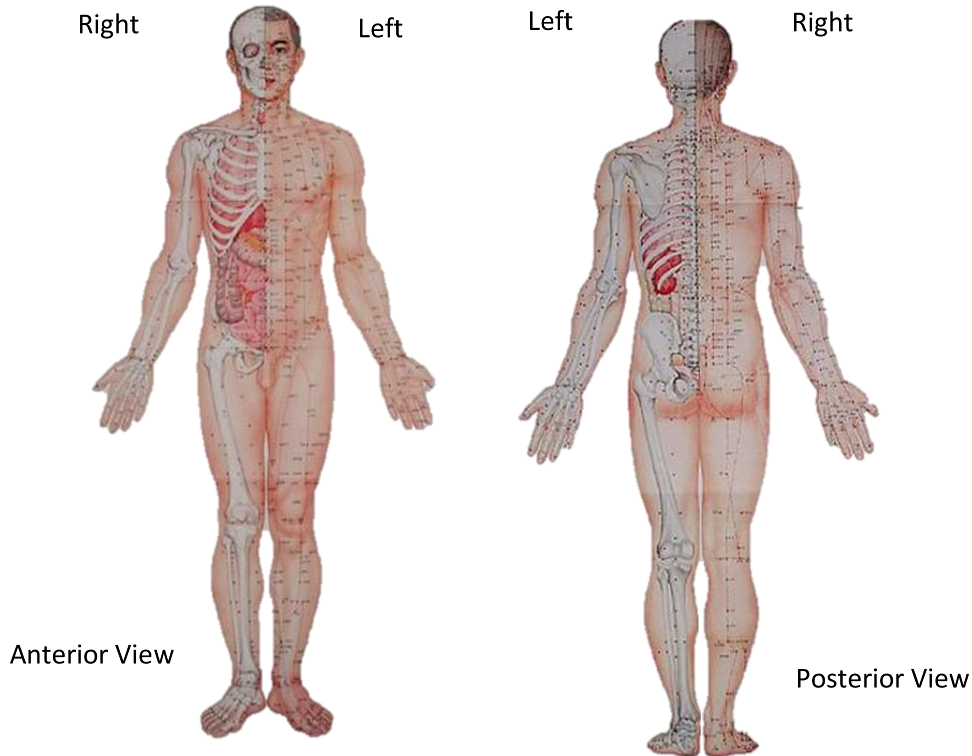

Figure 1 Bridgeman Art Library/ Universal Images Group Rights Managed/ For Educational Use Only

Pain or discomfort: ☐Slight ☐Moderate ☐Significant ☐Severe

Are you currently receiving treatment(s) for your discomfort? ☐Yes ☐No

If yes, please indicate what types of treatment(s) you have been receiving:

Have you had a previous office ergonomics assessment? If so, please describe and include date:

Date:

Is this assessment a preventative measure ☐ or related to a specific concern ☐?

Discuss your request for an ergonomic assessment with your supervisor? Completed: ☐Yes ☐No

Supervisor Comments:

Employee Signature:____ Date:__________________________

Please return form to: Supervisor