

Occupational Health and Wellness

Ergonomic Assessment Request

*Please return by fax to 519-780-1796

Or [upload to OHW Secure Drive](#)

Employment Information	
Full Name:	
Position Title and Role Summary:	
Department:	
Bargaining Group:	
Office Location:	
Telephone #	
Supervisor Name:	
Supervisor Email:	
Supervisor Extension:	

Ergonomic Assessment Request. Please indicate reason for assessment below

When signing this request and providing departmental coding information, the following has been acknowledged:

1. Cost of each assessment is between \$150.00 - \$200.00
2. If an assessment is cancelled within 48 hours of the appointment time, there will be a \$100.00 cancellation fee

Signatures			
Requested By:			
	Printed	Signature	Date
Supervisor			
	Printed	Signature	Date

GL Coding

Total Amount	Fund (3 digits)	Unit (6 digits)	Grant (6 digits)	Project (6 digits)	Object (6 digits)