



## Occupational Health and Wellness

Ergonomic Chair Fitting 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 Chair Fitting Request. Please indicate reason for assessment below and height of keyboard from floor (cm)**

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Signatures			
Requested By:			
	Printed	Signature	Date
Supervisor			
	Printed	Signature	Date