

Michigan Department of Licensing and Regulatory Affairs
 Equal Opportunity Office
 611 W. Ottawa St., 4th Floor
 Lansing, Michigan 48933
 FAX: (517) 373-6526

ERGONOMIC ASSESSMENT REQUEST BY EMPLOYEE

Please type or print a response to each of the items below in accordance with the instructions on the back. Return the completed form and attachments to the Equal Opportunity (EO) Office. The information you submit will be treated as confidential to the extent permitted. Please note that your request cannot be processed unless you attach medical documentation (noting your diagnosis and recommending an ergonomic evaluation), as well as a medical release form. For further information, contact the EO Office at (517) 335-5824.

1. Name	2. Employee ID #	3. Bureau / Division
4. Work County	5. Classification	6. Date of Birth / /
7. Work Address (home address if on leave)		8. Telephone Numbers Work () - Home () -
9. Describe your current job duties that are affected by your medical condition.		
10. Describe the functional limitations caused by your medical condition for which you are requesting an ergonomic assessment. Use additional pages if necessary. (Attach medical documentation.)		
11. Describe the modification needed and why you believe it would minimize or eliminate the functional limitations described in question 10.		
12. Have you previously had an Ergonomic Assessment completed by the State of Michigan? If yes, when and what Department did you work for?		
13. Immediate Supervisor Name and Telephone Number () -		
14. Employee's Signature	Date / /	

PURPOSE: Ergonomic assessments are a function of the Employee Health Management (EHM) "At-Risk" program. The purpose is to create an ergonomically healthy, productive work environment. This is accomplished through modification of workplace conditions and work procedures to enhance the capabilities of the employee. The Equal Opportunity Office (EO Office) has the responsibility for processing and approving the Department's ergonomic assessment requests from employees with medical conditions that affect the performance of their job duties. The Department is in support of this program.

CONFIDENTIALITY: Information in your request will be held confidential to the extent allowed by law.

INSTRUCTIONS FOR COMPLETING THE ERGONOMIC ASSESSMENT REQUEST

FORM: Information obtained or generated in processing your request may be released to individuals or agencies participating in the evaluation of your request.

FILING BY EMPLOYEE: Make a copy of this form. Keep the copy and submit the original to the EO Office. Consult the EO Office for assistance, if necessary.

<u>Questions</u>	<u>Instructions</u>
Questions 1 – 8	Complete all personal information
Question 9	Describe which job duties you are (or anticipate) having difficulty performing because of your medical condition.
Question 10	Describe the functional limitations of your condition which interfere (or may interfere) with performing the duties of your job. Please attach medical documentation regarding your condition and functional limitations.
Question 11	Describe the modifications you are requesting and indicate why you believe it would help.
Question 12	Enter whether or not you have previously had an Ergonomic Assessment completed while employed by the State of Michigan.
Question 13	Enter the name and telephone number of your immediate supervisor.
Question 14	Sign and date the form. If you are unable to sign the form, your designated representative may sign on your behalf. Also attach the At-Risk Disclosure form.

RESPONSE TIME: A response to the request or a request for an evaluation should be given to the employee from the EO Office within eight weeks after the date your completed Ergonomic Assessment request is received. If necessary, follow up with the EO Office.