



PRELIMINARY ERGONOMICS CHECKLIST

Description of Task: _____

Description of Location: _____

Assessed by: _____ Contact Phone Number _____ Date: _____

The purpose of this survey is to assist supervisors in identifying areas, jobs or tasks that may require ergonomic modifications. Please add any additional comments or call EHS to discuss your concerns. 304-293-3792

RISK IDENTIFICATION	YES	NO	COMMENTS
Does the job require physical handling such as carrying, lifting, lowering, pushing, pulling ?			
Are there excessive contact forces exerted on the body?			
Does the employee have difficulty gripping an object or tool, which has a smooth, slippery surface? (i.e., oily part, smooth knobs or handles)			
Are some objects difficult to grip?			
Does the work involve repetitive motions or many similar type repetitive movements?			
Are employees required to sit or stand continuously for more than two hours?			
Does the task require that any part of the body be maintained in a stationary or static posture?			
Does the task require the employee to work with any body part in an awkward position instead of a neutral position? (neutral defined as normal postures)			
Do employees exhibit awkward postures to overcome problems associated with glare, inadequate lighting or poor visibility?			
Do working heights or reaches cause employees to bend or reach beyond their comfort range?			
Does the workplace layout require the employee to have awkward or extreme movements?			
Does the layout of the workstation restrict movements of the employee's body, for example, by limiting leg room?			
Do observations indicate problems with the design of workstation seating?			
Are employees unsure of how to adjust their workstations to perform work comfortably?			
Do floors or sloped surfaces such as ramps pose a risk of slipping, cause problems for employees who stand on them for long periods, or cause problems for employees pushing or pulling objects?			

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RISK IDENTIFICATION	YES	NO	COMMENTS
Does the employee experience problems handling an object due to its size, shape or weight?			
Are there problems handling an object due to its condition? For example, is the object fragile, unbalanced or in-flexible?			
Are handles on containers an inappropriate size or shape, or not strong enough for the weight and size of the object being handled?			
Are handles for tools or equipment not appropriate in size, shape or height?			
Is vibration from the tool or equipment transmitted to the employee's hand/arm?			
Is the palm or base of the employee's hand used like a hammer for striking?			
Do objects, tools or parts of the workstation with hard, sharp or uneven surfaces put pressures on part of the body ?			
Is the employee exposed to extreme cold or hot temperatures?			
Are any body parts exposed to cold from exhaust air, cold liquids, or other objects?			
Is the employee's whole body exposed to vibration for significant portions of worker's shift?			
If employee wears gloves, do their gloves hinder gripping or restrict movement?			
Do records, observations or employee comments indicate fatigue or postural problems from the use of assigned personal protective equipment?			
Do peak workloads or sudden increases in pace occur with the employee's task?			
Do employee comments indicate a risk of adverse health effects due to ergonomic factors in the job or task being evaluated?			

Send completed forms to

Environmental Health and Safety
 PO Box 6551
 Attention: Ergonomics Survey

Or

Fax to 304-293-7257