OFFICE OF AFFIRMATIVE ACTION

Ergonomic Workspace Evaluation Request

UMKC is committed to providing employees with workspaces free from known or potential hazards and that will allow employees to be productive and comfortable. For UMKC to best determine whether an employee's workspace arrangement needs to be modified, the employee must request an ergonomic evaluation of their workspace by completing the form below.

Directions and Procedures

Employees must complete all information on the request form and submit it to their immediate supervisor for signature. Incomplete forms will be returned.

Please note: **Submission of this request does not guarantee the modification of your workspace. The University may exercise discretion as to whether a modification of an employee's workspace is appropriate and reasonable.**

Employee Information

Employee Name (print or type): ____

Title: ____

Email: ______________________________ Phone: __________________________

Supervisor: ____

Email: ______________________________ Phone: __________________________

Work Location: ____

Ergonomic Workspace Questionnaire

All employees are required to certify the following prior to submitting an Ergonomic Workspace Evaluation Request:

_____ I have downloaded and reviewed the Ergonomics Self-Assessment Worksheet (https://info.umkc.edu/hr/hr-service-center/forms/)

_____ I have made changes based on the Self-Assessment

_____ It has been *at least two weeks* since making changes and pain/discomfort continues

_____ I understand that submission of this request does not guarantee modification of my workspace

_____ I understand that if I have a documented disability related to this request, I must also complete the Disability Accommodations Request Form and submit documentation from my healthcare provider (https://info.umkc.edu/hr/hr-service-center/forms/)

Reason for Request

I am requesting an ergonomic evaluation due to the following (check all that apply):

_____ I am experiencing pain or discomfort when engaged in activities at my workspace.

_____ My healthcare provider has recommended that an evaluation be conducted.

_____ Other reasons; please be as specific as possible:

Working Conditions

Is your pain/discomfort related to work activities? Yes No

When did the pain/discomfort start? __________________

What are you typically doing when you notice the pain/discomfort?

How often do you experience the pain/discomfort?

Describe the pain/discomfort:

What makes the pain/discomfort worse or better?

Have you seen a medical professional to assist with the pain/discomfort? Yes No

If so, when? ___________________________________

Have you filed a Workers' Compensation claim? Yes No

Have you requested accommodations for a documented disability? Yes No

Approval for Submission of Ergonomic Workspace Evaluation Request

Supervisor Name (Printed): _________________________

Supervisor Signature: ______________________________ Date: _________________

Submission to the Office of Affirmative Action

Please submit the completed form by email, fax, postal mail, or in-person drop-off:

Email: wyattsb@umkc.edu

Fax: 816-235-6537

Postal Mail: Dr. Sybil Wyatt, Office of Affirmative Action, University of Missouri – Kansas City, 5115 Oak Street, Room 212, Kansas City, MO 64112

Drop-Off: Office of Affirmative Action, Administrative Center Room 212