Maricopa County
Business Strategies and Health Care Programs

ERGO-SMART REQUEST FORM – Ergonomic Evaluation
Maricopa County Employee Benefits Division
(One Form per Employee)

Employee ID: _____ Email Address: _____

First Name: _____ Last Name: _____

Work Phone #: _____ Department: _____

Job Title: _____ Supervisor's Name: _____

Supervisor's Phone #: _____ Supervisor's Email: _____

Note: Your supervisor/manager may be notified by email of this request

Requested by: Self ❒ Supervisor ❒ Department Facilitator ❒ Physician/Therapist ❒ Other ❒ _____

Section 1: Pain and/or Discomfort Level

a) Is the employee feeling chronic pain and/or discomfort? Yes❒ No❒ If no, skip to Section 2.

b) On a scale of 1-10 (1 = little pain, 10 = intolerable pain), what is the severity of the pain and/or discomfort?<>

c) Identify the area causing the most pain and/or discomfort:

- ❒ Wrist
- ❒ Neck
- ❒ Shoulders
- ❒ Lower back
- ❒ Upper back
- ❒ Legs
- ❒ Other_____

d) Is the employee currently being treated by a medical provider? Yes❒ No❒

If yes, please indicate whom the employee is being treated by: Physician ❒ Chiropractor ❒ Therapist ❒ Other ❒

e) Is this an American's with Disabilities Act request? Yes❒ No❒

If yes, please attach a copy of special accommodations to this request.

*To assist with expediting the request, please attach additional documents such as copies of emails, physician requests or other related documentation.

Section 2: Work Space Information

Please provide a brief description of areas to be addressed or issues you are having:

Physical Worksite Address:_____Campus: Other

Contact person (if different than employee or supervisor): _____Phone Number: _____

Best date/time to contact you to schedule your appointment: _____ A.M.❒ P.M.❒

Request can also be sent via interoffice to: Maricopa County Employee Benefits Division,
301 W. Jefferson St. Suite #3200 **OR** via fax to 602-506-2354