



Maricopa County

Employee Benefits and Health

ERGO-SMART INDIVIDUAL EVALUATION REQUEST FORM

Maricopa County Wellness Works Program

Section 1: Pre-Assessment

Evaluation Submitted By: Self Supervisor Department Facilitator Human Resources Other _____

NOTE: The disclaimer agreement on the back of this request form must be completed by the individual in need of the evaluation.

The employee has completed the [Ergonomic Self-Assessment](#)? Yes No If no, please complete prior to submitting form.

The employee has informed his/her supervisor of the ergonomic-related concern? Yes No If not, please inform him/her.

Section 2: Employee Information

Employee ID: _____ Email Address: _____

First Name: _____ Last Name: _____

Work Phone #: _____ Department: _____

Job Title: _____ Supervisor's Name: _____

Work Address: Include Suite Number/Cubicle Number, ie., 301 W. Jefferson St., Suite 3200, Phoenix

Work Address: _____ Suite/Cubicle # _____ City _____

Contact person (if other than employee or supervisor): _____

E-mail address (if other than employee or supervisor): _____

Section 3: Pain and/or Discomfort Level

a) Is the employee feeling chronic pain and/or discomfort? Yes No If no, skip to Section 4.

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 4: Work Space Information

Please provide a brief description of work area(s) to be addressed or health issues you are experiencing:

Ergonomic Disclaimer Agreement

1. The evaluation and recommendation(s) made by the ergonomic specialist is not intended to replace or to be considered medical advice. The recommendation(s) are made to help reduce risks for injury and are not to cure an injury(s). There is no promise or guarantee that every health risk will be eliminated. If for some reason you experience new or increased symptoms after your ergonomic evaluation, it is recommended that you seek the advice of a healthcare professional. The ergonomic specialist does not guarantee that further injury cannot occur from the implementation of the ergonomic recommendation(s).
2. The Ergonomics Unit is not responsible for purchasing any recommended equipment. All purchases are the responsibility of the employee's Department.
3. I, as the individual requesting the evaluation, certify that I have read and understand the contents of the Ergonomic Disclaimer Agreement.
4. Print Name _____ Date _____

Please print name and date this form and return by either:

- Emailing to: BenefitsService@mail.maricopa.gov
- Sending interoffice mail to 301 W. Jefferson, Suite 3200
- Sending electronically by clicking the "Submit" button on the form