REQUEST FOR ERGONOMIC EVALUATION

|  |  |  |
| --- | --- | --- |
| Name of Employee | Click here to enter text. | Phone: Click here to enter text. |
| Name of Supervisor | Click here to enter text. | Phone: Click here to enter text. |
| Department Click here to enter text. | | | |
| Location Click here to enter text. | | | |

This evaluation is requested based on medical information received by OMS from the medical provider.

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| **Please complete the following (treating provider)** |

Part of Body Click here to enter text.

Purpose or Focus of Ergonomic Evaluation Click here to enter text.

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Date requested: Click here to enter a date.

Healthcare provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please email this form to** [**medicalinfo.oms@montgomerycountymd.gov**](mailto:medicalinfo.oms@montgomerycountymd.gov)

**or fax 240 777-5132**

**Medical documentation from your healthcare provider *must be included* with this request.**

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| **OMS Completion** |

Date Received by OMS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Evaluated by (OMS provider):­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Completed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date sent to Risk Management\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_