Occupational Health
INTERNATIONAL

Ergonomics Evaluation General Questionnaire

Name of the company		
Nature of business/ industry		
Location of the offices/ workplaces		
Number of offices/ staff to be evaluated		
Contact person/ department		
Tel:	**Mobile:**	**E:**

Job related details:

Sr. No	Job title/ Job category	No. of employees in each category	Brief job description/ Any specific comments

Answer (Yes or No). If "Yes", please provide more details:

Office job?	☐ **YES**	☐ **NO**	______________________
Field job?	☐ **YES**	☐ **NO**	______________________
Employees working in shifts (day/ night)?	☐ **YES**	☐ **NO**	______________________
Staff driving/ traveling for business purposes?	☐ **YES**	☐ **NO**	______________________
Working in front of computers daily? Approximate number of hours/day of work in front of PC.	☐ **YES**	☐ **NO**	______________________
Working in sitting position long hours?	☐ **YES**	☐ **NO**	______________________
Working in awkward position on a daily basis in the workplace?	☐ **YES**	☐ **NO**	______________________
Manual handling? Lifting of heavy objects?	☐ **YES**	☐ **NO**	______________________
Repetitive movements as routine daily activity?	☐ **YES**	☐ **NO**	______________________
Climbing/ working at heights?	☐ **YES**	☐ **NO**	______________________
Communication through telephones as major part of the employees' job?	☐ **YES**	☐ **NO**	______________________
Employees' age range / gender (how many M and how many F)?	☐ **M**	☐ **F**	______________________

Kindly send the duly filled questionnaire to businessdevelopment@occupational-healthcare.com. The proposal will be prepared by the Occupational Medicine Specialist based on the information provided.

OHI/F205/ERGEVAQUE

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