The University of Western Ontario
MSD Prevention Program

In-Depth Risk Assessment Referral – Form 2C

Completed by Ergonomic Team or Supervisor: _____ Date: _____

This form may be used for in-depth job assessment or a referral for the individual needs of a worker.
FAX to: Ergonomics ext 82079 or email ruruski2@uwo.ca

Worker Name (ID): _____ Phone Ext.: _____
Job Title: _____ Union Group: _____
Location (Building/Room #): _____ Department: _____
Supervisor: _____ Phone Ext.:_____

Services Requested:
- □ MSD Risk Assessment
- □ Job Coaching
- □ Job Demands Description
- □ Office Ergonomics Assessment
- □ Lab Ergonomics Assessment
- □ Vehicle Ergonomics Assessment
- □ Safety Assessment
- □ Group Training/Education

Priority:
- □ High (<2 weeks)
- □ Medium (2-4 weeks)
- □ Low (> 4weeks)

MSD Screening Assessment Results:

_____
_____
_____
_____
_____
_____

Individual Worker Symptoms:

_____
_____
_____
_____
_____
_____

Other Information:

_____
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