An ergonomics checklist is an easy-to-use tool for general use and can be used for self-evaluations. Review these common ergonomic problems. A question answered “yes” may indicate an ergonomic risk factor is present which requires further analysis.

Manual Material Handling

1. Is there lifting of loads, tools, or parts?  **Yes**  **No**
2. Is there a lowering of tools, loads, or parts?  **Yes**  **No**
3. Is there overhead reaching for tools, loads, or parts?  **Yes**  **No**
4. Is there bending at the waist to handle tools, loads, or parts?  **Yes**  **No**
5. Is there twisting at the waist to handle tools, loads, or parts?  **Yes**  **No**
6. Do normal loads/lifts weigh more than 50 pounds?  **Yes**  **No**

Physical Energy Demands

1. Do tools and parts weigh more than 10 pounds?  **Yes**  **No**
2. Is reaching greater than 20 inches?  **Yes**  **No**
3. Is bending, stooping, or squatting a primary task activity?  **Yes**  **No**
4. Is lifting or lowering loads a primary task activity?  **Yes**  **No**
5. Is walking or carrying loads a primary task activity?  **Yes**  **No**
6. Is stair or ladder climbing with loads a primary task activity?  **Yes**  **No**
7. Is pushing or pulling loads a primary task activity?  **Yes**  **No**
8. Is reaching overhead a primary task activity?  **Yes**  **No**
9. Does a task above require at least five work cycles within a minute?  **Yes**  **No**
10. Do workers report rest breaks and fatigue allowances are insufficient? **Yes**  **No**

Other Musculoskeletal Demands

1. Do jobs require frequent, repetitive motions?  **Yes**  **No**
2. Is there frequent bending of the neck/shoulder/elbow/wrist/fingers?  **Yes**  **No**
3. While seated, do reaches for tools and materials exceed 15 inches?  **Yes**  **No**
4. Is the worker unable to change his or her position often?  **Yes**  **No**

**This model form/template must be customized to meet your Agency’s needs.**

1. Does the work involve forceful, quick, or sudden motions?  **Yes**   **No**
2. Does the work involve shock or rapid buildup of forces? **Yes**  **No**
3. Is finger-pinch gripping used?  **Yes**  **No**
4. Do job postures involve sustained muscle contraction of any limb? **Yes**  **No**

Computer Workstation

1. Do operators use computer workstations for more than 4 hours a day?  **Yes**  **No**
2. Are there complaints of discomfort from working at these stations?  **Yes**  **No**
3. Is the chair or desk nonadjustable?  **Yes**  **No**
4. Is the display monitor, keyboard, or document holder non-adjustable?  **Yes**  **No**
5. Does lighting cause glare or make the monitor screen hard to read?  **Yes**  **No**
6. Is the room temperature too hot or too cold?  **Yes**  **No**
7. Is there irritating vibration or noise?  **Yes**  **No**

Environment

1. Is the temperature too hot or too cold?  **Yes**  **No**
2. Are worker's hands exposed to temperatures less than 70 degrees?  **Yes**  **No**
3. Is the workplace poorly lit?  **Yes**  **No**
4. Is there glare?  **Yes**  **No**
5. Is there excessive noise (distracting or/producing hearing loss)?  **Yes**  **No**
6. Is there upper extremity or whole-body vibration?  **Yes**  **No**
7. Is air circulation too high or too low?  **Yes**  **No**

General Workplace

1. Are walkways uneven, slippery, or obstructed?  **Yes**  **No**
2. Is housekeeping poor?  **Yes**  **No**
3. Is there inadequate clearance or accessibility for performing tasks?  **Yes**  **No**
4. Are stairs cluttered or lacking railings?  **Yes**  **No**
5. Is proper footwear worn? **Yes**  **No**

Tools

1. Is the handle too small or too large?  **Yes**  **No**
2. Is the handle shaped to cause a worker to bend the wrist?  **Yes**  **No**
3. Is the tool hard to access?  **Yes**  **No**
4. Does the tool weigh more than 10 pounds?  **Yes**  **No**
5. Does the tool vibrate excessively?  **Yes**  **No**
6. Does the tool cause excessive kickback to the operator?  **Yes**  **No**
7. Does the tool become too hot or too cold? **Yes**  **No**

Gloves

1. Do gloves require a worker to use more force when performing tasks?  **Yes**  **No**
2. Do the gloves provide inadequate protection?  **Yes**  **No**
3. Do gloves present a catch point on the tool or in the workplace?  **Yes**  **No**

Administration

1. Is there little worker control over the work process?  **Yes**  **No**
2. Is the task highly repetitive and monotonous?  **Yes**  **No**
3. Is this a critical task with high accountability and minimal error?  **Yes**  **No**
4. Are work hours and breaks poorly organized? **Yes**  **No**

Notes/Comments:

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Department Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_