SISC
Self-Insured Schools of California
Schools Helping Schools

Date of assessment:

WORKSTATION ASSESSMENT

Section 1: Assessment

Name:	Height: 5 ft. 0 in.	Hours worked per day: 0 hrs/day
District:	Dominant hand: ☐ L ☐ R	Hours on phone: 0 hrs/day
Site:	Corrective Lenses: ☐ None ☐ Reading/Computer ☐ Bifocal/Trifocal/ Progressive ☐ Contacts	Hours at desk: 0 hrs/day
Position:		District Contact: FOR SISC USE ONLY
Phone:		Contact's email: FOR SISC USE ONLY
	WC Claim Y☐ N☐	Adjuster: FOR SISC USE ONLY

Section 2: Discomfort Survey

Is there discomfort in the:	How severe is the discomfort? None	Slight	Moderate	Severe
Neck	⊙	○	○	○
Upper back	⊙	○	○	○
Lower back	⊙	○	○	○
Eyes ☐ L ☐ R Both ☐	⊙	○	○	○
Shoulder ☐ L ☐R Both ☐	⊙	○	○	○
Upper arm ☐ L ☐ R Both ☐	⊙	○	○	○
Elbow ☐ L ☐ R Both ☐	⊙	○	○	○
Forearm ☐ L ☐ R Both ☐	⊙	○	○	○
Wrist ☐ L ☐ R Both ☐	⊙	○	○	○
Hand ☐ L ☐ R Both ☐	⊙	○	○	○
Hip ☐ L ☐ R Both ☐	⊙	○	○	○
Buttocks ☐ L ☐ R Both ☐	⊙	○	○	○
Knee ☐ L ☐ R Both ☐	⊙	○	○	○
Foot ☐ L ☐ R Both ☐	⊙	○	○	○

Please list any pre-existing conditions/surgeries that may be contributing to these discomforts: