North Dakota Workforce Safety & Insurance
*Putting Safety to Work*

**ERGONOMIC INITIATIVE**
**EMPLOYER APPLICATION**
EMPLOYER SERVICES /
LOSS CONTROL DIVISION
SFN 59017 9/2011

1600 EAST CENTURY AVENUE, SUITE 1
PO BOX 5585
BISMARCK ND 58506-5585
TELEPHONE NUMBER (701) 328-3800
TOLL FREE FAX NUMBER 1-888-786-8695
TDD NUMBER (for the hearing impaired only)
(701) 328-3786
www.WorkforceSafety.com

**Please type or print clearly. To be considered for participation in this program, all employers must complete Sections 1 & 2 of this application. The WSI Ergonomic Coordinator will review your application to determine program eligibility. You can expect a written reponse within 10 working days, along with the list of providers in your area who are participating in this program. It will be the employer's responsibility to select which provider they choose to work with. Thank you for your interest in providing a safe workplace for your employees.**

## Section 1 – Employer Information

| Employer's Business Name | | WSI Employer Account Number | |
|---|---|---|---|
| Employer Contact Name | Title | Phone Number | Email Address |
| Mailing Address | City | State | Zip |

Industry Group

☐ Office Setting
☐ Construction
☐ Trucking
☐ Other (please specify)_____
☐ Manufacturing
☐ Healthcare

## Section 2 – Statement Of Need For Ergonomic Assistance

**Provide a summary of the need/problem as it relates to ergonomics in your workplace.**
Please provide specific information of the ergonomic issue, such as: job being performed, number of repetitions, awkward positioning, weights, frequencies, etc. (i.e. required to squeeze, while flexing wrist, 25 times per minute to tighten bolts). Consider providing pictures or video for further clarification of problem.

Have you had any ergonomic related injuries/claims in the past year?
If so, please provide details:

## Employer Signature

| Employer Representative | Date |
|---|---|
| | |

## (For WSI Use only)

## Signature Of Approval

| WSI Representative | Date |
|---|---|
| | |