Eastern Health

Workplace Health, Safety and EFAP

Office Workstation
Ergonomic Equipment Funding Request

Date: DD/MONTH/YYYY

Manager's Name: _____

Program/Department: _____

Department Code: _____

Name of employee for whom the equipment will be purchased: _____

Name of Occupational Therapist recommending equipment (if applicable): _____

Equipment Name and Model Number	Supplier	Cost

Manager's Name: _____ Manager's Signature: _____ Date: DD/MONTH/YYYY

☐ **Funding Approved** ☐ **Funding Denied**

Occupational Therapist III, Occupational Health

Name: _____ Signature: _____ Date: DD/MONTH/YYYY

Please Email all requests to:

Mysafety@easternhealth.ca

Clear Form

If you have any questions please contact 777-7777, x.3, x.3

The personal information is being collected under the authority of Sections 29, 30 and 31 of the Personal Health Information Act and will be used for assisting employee's with return to work, accommodations at work and/or medical issues affecting their ability to work. If you have questions concerning the collection, use, and disclosure of this information, please contact Human Resources Workplace Health, Safety and EFAP. If you have questions relating to Privacy and Access, please contact 777-8025.