Staff Feedback Survey

Department		Work Area	
Job Name		Room no./Machine no./Location	

What is the most physically difficult task you do?

How often do you perform this task?

What is the second most physically difficult task you do?

How often do you perform this task?

Do any of your job tasks require you to:

Repeat the same movements or actions more than a few times a minute for more than 30 minutes at a time? Y ☐ N ☐

If yes, list the three most "repetitive" tasks:

1) _____

2) _____

3) _____

lift, push, pull, or move heavy items? Y ☐ N ☐

If yes, list the three heaviest items you lift, push, pull, or move:

1) _____

2)

3) _____

Do any of your job tasks require you to:

work in awkward postures (working with arms above the shoulder, bending/twisting at the waist, lifting while bending or twisting, bending wrists up/down frequently, reaching behind the body)? Y ☐ N ☐

if yes, list the three most awkward or uncomfortable postures you must work in and the tasks where they are required:

1) _____

2) _____

3) _____

Is the lighting in your work area suitable? Y ☐ N ☐

If no, please indicate why not:

- Too much light/too bright/glare/reflections ☐
- Not enough light/dull/shadows ☐
- Lights in the wrong place ☐
- Sunlight causes problems (some or all of the day) ☐

Is the temperature in your work area suitable? Y ☐ N ☐

If no, please indicate why not:

- Too cold (in winter or due to air conditioning) ☐
- Too warm (in summer or thermostat too high) ☐
- Drafts or other issues ☐

Is the noise level in your work area satisfactory? Y ☐ N ☐

If no, please say why not:

- Too noisy due to equipment/machines ☐
- Too noisy due to co-worker conversations/music ☐

Please check any of the following that are a concern or problem in your work area and provide some detail.

Concern/Problem	Details of the concern/problem
■ Seating	_____
■ Workstation adjustability	_____
■ Working reaches	_____
■ Repetitive motions	_____
■ Heavy lifting	_____
■ Awkward postures	_____
■ Mental strain	_____
■ Too much work variety	_____
■ Too little work variety	_____

Please check any of the following that are a concern or problem in your work area and provide some detail.

Concern/Problem	Details of the concern/problem
■ Poor hand tools	_____

- Noise _____
- Lighting _____
- Temperature _____
- Stress _____
- Poor control design/layout _____
- Poor display design/layout _____
- Standing/walking _____
- Lack of control over process _____

Do you ever feel any pain or discomfort while at work or when leaving at the end of your shift? Y ☐ N ☐

If yes, please indicate of the types of discomfort you feel:

1) _____
2) _____
3) _____

List five things you would most like to see changed in the design, set-up or organization of your work.

1) _____
2) _____
3) _____
4) _____
5) _____

Do you have any suggestions to fix or eliminate some of the concerns you have with your job or ideas to make the job better? If so, write them down on the back of this page or talk them over with your supervisor.

NOTE: Your ideas can be simple or complex. All ideas will be evaluated and discussed. It is very likely that you will be asked to participate in these discussions. Any decision regarding your suggestion will be made known to you and you will be advised as to why your idea or suggestion will or will not be implemented.

Modified from Part 3B: MSD Prevention Toolbox - Beyond the Basics
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