

DSE Assessment Form

Note: Use one copy of this Form for each workstation. – send to your H&S Manager after completion.

Assessment Ref. No.:	Leave blank	Date:	
Name of User:		Job Title:	
Department/Team			
Line Manager:			
Average number of hours per day spent using screen:			

EQUIPMENT AND FURNITURE (Enter Y/N in YES or NO box for each question)

1.0	Display Screen	Y	N	Notes
1.1	Is the top of the screen at or slightly below eye level?			
1.2	Is the screen approximately an arm's length away?			
1.3	Is the screen free from glare or reflections?			
1.4	Are the brightness and contrast settings comfortable?			
2.0 Workstation Setup				
2.1	Is the chair height adjustable?			
2.2	Does the chair provide adequate lumbar support?			
2.3	Are feet flat on the floor or supported by a footrest?			
2.4	Is the desk at a comfortable height for typing and writing?			
3.0 Input Devices				
3.1	Is the keyboard placed directly in front of the user?			
3.2	Are wrists straight and not resting on sharp edges?			
3.3	Is the mouse within easy reach and on the same level as the keyboard?			
4.0 Environment				
4.1	Is the workstation adequately lit without causing glare?			
4.2	Is the noise level conducive to concentration?			
4.3	Is the workspace at a comfortable temperature with good airflow?			
5.0 Work Routine				
5.1	Does the user take regular breaks away from the screen?			
5.2	Are tasks varied to prevent prolonged periods of repetitive activity?			
6.0 User Comfort				
6.1	Does the user experience any discomfort or pain during or after DSE use?			
6.2	Has the user noticed any changes in vision or experienced eye strain?			

USER (Enter Y/N in YES or NO box for each question)

USER (Enter Y/N in YES or NO box for each question)

I declare that the information provided above accurately reflects my current workstation arrangements.

Employee Signature:		Date:	
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OFFICIAL USE – TO BE COMPLETED BY THE OFFICE LEADER/SAFETY OFFICER AS APPROPRIATE

CONCLUSIONS – Details of risks identified

ACTION – Details of Actions required

**Issues identified relating to pre-existing conditions and occupational health concerns shall be discussed with the RSK SHEQ team.*

Action	Person Responsible	Target Completion	Completion Date

ADDITIONAL COMMENTS

**In rare instances corrective actions may have been recommended that the DSE user chooses not to adopt. Any such occurrence shall also be documented in this section of the form and signed by the DSE user. The RSK SHEQ team shall also be notified and provide guidance accordingly.*

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Reviewer Name:		Reviewer Signature:	
Reviewer Job Title:		Date of Review:	

Copies of this Assessment are to be given to: Workstation User, Office H&S file.