HEALTH AND SAFETY (DISPLAY SCREEN EQUIPMENT) REGULATIONS 2002

Employers have a duty to provide a healthy and safe working environment. This assessment is to provide information required under the above regulation. The completed assessments will assist you and your employer to achieve the required standards of care and improve your comfort.

Please answer all the questions and provide comment where requested. When completed pass to the DSE assessor who will be contacting you to discuss your workstation and any problems you have highlighted below.

Name	**Location**
Department	
Do you use a laptop? YES/NO	Do you have a docking station? YES/NO
Do other people use your workstation? YES/NO	
Do you work outside of the office eg home/car YES/NO	
Please record related equipment e.g. printer, mouse, local lighting etc.	
Please describe any concerns or problems you have regarding the use of the display screen equipment or related equipment.	

1. GENERAL WORK PATTERN -

1.	What is the nature of your work eg Numbers input, text?	
2.	What is the average time you spend working on a keyboard per day?	
3	What is the average time you spend doing other work per day eg filing, telephone?	
4	Are there opportunities for regular breaks from using display screen equipment?	YES/NO
5	Do you share the workstation with other users?	YES/NO
6	Have "peaks and troughs" in workload been eliminated?	YES/NO
7	Have you had training in health and safety risks of using DSE?	YES/NO

2. THE DISPLAY SCREEN and EQUIPMENT -

1.	Does the screen swivel and tilt easily and adjust to suit your needs?	YES/NO
2.	Does the screen stand on an adjustable work surface, or is it possible to achieve the correct viewing height by other means?	YES/NO
3.	Does the screen produce a clear, stable, flicker free image?	YES/NO
4.	Does the screen have a contrast or brightness control?	YES/NO
5.	Are the characters on your screen clear and easily read?	YES/NO
6.	Are characters well-defined and of adequate size?	YES/NO
7.	Is there adequate space between individual characters and lines of text?	YES/NO
8.	Is the screen position easily altered due to the weight, size and cable lengths?	YES/NO
9.	Is the cursor easy to find and see?	YES/NO
10.	Do you use the mouse infrequently?	YES/NO
11.	Do you regularly use the short cut keys?	YES/NO
12.	Is the screen cleaned at regular intervals?	YES/NO
13.	Is the screen free from glare or reflections?	YES/NO

Source of glare or reflection - please describe	
14. Is the working surface or desk, non-reflective i.e. of a matt finish?	YES/NO
15. Is the display screen equipment casing of a matt finish?	YES/NO
16. Is the keyboard of non-reflecting material?	YES/NO
17. Is the keyboard separate from the screen?	YES/NO
18. Is the keyboard easy to move?	YES/NO
19. Is the keyboard adjustable for tilt and comfort?	YES/NO
20. Is the key board stable when in use?	YES/NO
21. Are the base and screen separate units?	YES/NO
22. Is the mouse comfortable to use?	YES/NO
23. Do you have enough space to move the mouse?	YES/NO

3. SOFTWARE -

1. Do you find the computer programmes/systems user friendly?	YES/NO
2. Is the software suitable for the tasks you are required to perform?	YES/NO
If NO to either please explain -	

4. WORKSTATION -

1. Is the workstation comfortable for working?	YES/NO
If the answer is NO describe problem/s	
2. Is the work desk stable?	YES/NO
3. Is the desk chair stable?	YES/NO
4. Are there arms on the chair?	YES/NO
5. Is the chair on castors?	YES/NO
6. Can the height of the seat be adjusted to suit your personal comfort?	YES/NO
7. Is the front of the seat rounded and the surface padded?	YES/NO
8. Can the chair back be adjusted forward, backwards and for height?	YES/NO
9. Are the chair adjustment mechanisms easy to use?	YES/NO
10. Does the chair cause pressure on the backs of the thighs, knees or back?	YES/NO
11. If you have special seating needs, have these been met e.g. for wheel chairs, chronic back pain, other?	YES/NO
12. Can the chair and your legs be positioned under the desk with comfort?	YES/NO
If NO please describe problem	
13. Have you been trained to adjust the chair to meet your personal comfort?	YES/NO
14. When seated in an adjusted chair can your feet rest flat on the floor?	YES/NO
15. If NO has a footrest been provided?	YES/NO
16. When seated in adjusted chairs is your head, neck and shoulders in a natural and comfortable position?	YES/NO

5. SOURCE DOCUMENTS -

1. Is the document holder at the same viewing distance and height as the screen?	YES/NO

6. WORK COMFORT -

1. Is there room for your hands and arms to rest on the front surface of the desk when the keyboard is in the working position?	YES/NO
2. When the hands are over the keys are the upper arms vertical to the body?	YES/NO
3. When the hands are over the keyboard in the working position, are the wrists naturally straight?	YES/NO

7. ENVIRONMENT -

1. Has background noise been controlled to prevent distraction and interference with speech or telephone?	YES/NO
If NO please identify source	
2. Is the level of light comfortable?	YES/NO
If NO please comment	
3. Has local lighting been supplied where required?	YES/NO
4. Is there sufficient working and storage space, to allow easy access to the workstation?	YES/NO
5. Does the workspace permit reasonable variation of furniture and equipment?	YES/NO
6. Have all sources of excessive heat been eliminated or controlled to ensure comfort?	YES/NO
7. Have the leads, cables and plugs been arranged to remove risks of slips, trips or falls?	YES/NO

8. EYE HEALTH -

1. Do you experience dry eyes at work?	YES/NO
2. Do you have regular eye tests?	YES/NO
3. Do you wear glasses* or contact lenses*? (*delete as appropriate)	YES/NO
When was your last eye test? ……	

9. REPORTING -

1. Who do you report any problems with the DSE to? …….

Thank you for completing the assessment form.

Date completed _____ Signed _____

For office use

Date received by Assessor…… Name……

Appointment date and time for completion of assessment……

Date of report to Management of any action points……

Date action completed…… Review Date……

FOR ASSESSORS USE ONLY

GENERAL NOTES (for use before starting)

ASSESSMENT NOTES (for use during assessment)

ACTION PLAN Designate a risk rating – High, Medium, Low

High: Action within 1 month
Medium: Action within 3 months
Low: Reduce as far as reasonably practicable