

# Glovebox Worker Ergonomic Assessment Tool

Your answers to these questions will be kept confidential; the answers will be used to determine the ergonomic risk category. Please return this completed form to your first line manager (FLM). FLMs: Please score using the GB Survey Score spreadsheet, and forward the spreadsheet, and this form to Occupational Medicine: [medical\\_request@lanl.gov](mailto:medical_request@lanl.gov), or by interoffice mail to Terese Ford, OM-OMO, MS D421.

Worker Name: \_\_\_\_\_ Initials and date \_\_\_\_\_

Z #: \_\_\_\_\_

TA, Building, Room #'s where you perform the majority of your GB work: \_\_\_\_\_

1. Approximately how long have you been a glovebox worker? \_\_\_\_\_ years
2. How many weeks out of the year do you perform GB work? \_\_\_\_\_ weeks
3. How much time do you spend working in a GB in a typical workday? \_\_\_\_\_ hours per day
4. After how many minutes of GB work do you take a break? \_\_\_\_\_ minutes  
 How long is each break? \_\_\_\_\_ minutes  
 What is the longest duration you have worked in a GB without a break? \_\_\_\_\_ minutes

**5. What type of gloves do you use most frequently?**

- |  |  |
|--|--|
| <input type="checkbox"/> Hypalon 15 mil                            | <input type="checkbox"/> Hypalon 30 mil (lead loaded)  |
| <input type="checkbox"/> Hypalon 30 mil                            | <input type="checkbox"/> Viton 25 mil                  |
| <input type="checkbox"/> Hypalon/Polyurethane 22mil (blue & white) | <input type="checkbox"/> Other – please specify: _____ |

**6. Approximately what percent of your GB work requires over gloves? \_\_\_\_\_ %**

**7. How frequently do you perform the following GB tasks? (enter a number between 0 and 5, 5= most frequent, 1=infrequently, 0= never perform the task) (Example photos are included on back page)**

- Heavy lifting (≥15lbs)
- Fine motor activities (e.g. using tweezers or allen wrenches)
- Lateral transfer of items (e.g. in/out of airlock, passing items down the length of a glovebox)
- Gross motor activities (e.g. moving canisters)
- Significant forward reaching (arms completely straight)

**8. Please indicate your average daily mental stress level:**

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10  
 (no stress) (extreme stress)

**9. Please indicate your average physical comfort level while working in a GB:**

0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10  
 (no discomfort) (extreme discomfort)

**10. Have you experienced any physical pain, tingling, or numbness, either in the past or the present that you attribute to your GB work? \_\_\_\_ YES \_\_\_\_ NO**

If YES, please mark an X in the corresponding cells below for past and present symptoms. Mark all that apply.

Have you reported a glovebox related injury to Occupational Medicine? \_\_\_\_ YES \_\_\_\_ NO

Body Part	Thumb	Hand	Wrist	Elbow/Forearm	Shoulder	Neck/Upper Back	Other (Please Specify)
<b>Past</b>							
<b>Present</b>							

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**Comments** (Please include the following. Describe any glovebox related injury, or glovebox design feature that causes pain or discomfort. Describe any suggestions that would improve efficiency, safety, or ergonomic conditions in your glovebox work.):



Gross Motor Activities  
(e.g. moving canisters)



Fine Motor Activities-Pinch Gripping  
(e.g. using tweezers/allen wrench)



Significant Forward Reaching  
(arms completely straight)



Lateral Transfer of Items  
(e.g. in/out of airlock)