

ADA Physician Information – RSK – F204C
Sacramento City Unified School District

Patient/Employee Name: _____

Job Title: _____

Date this patient/employee last examined: _____

What is the nature of this patient/employee's impairment? _____

How long is this impairment expected to last: _____

Does this impairment limit the patient/employee's ability to do any of the following? If yes, please explain the limitation(s).

- | | |
|-------|-------------------------|
| _____ | Seeing |
| _____ | Hearing |
| _____ | Breathing |
| _____ | Walking |
| _____ | Speaking |
| _____ | Learning |
| _____ | Caring for him/herself |
| _____ | Performing manual tasks |
| _____ | Working |

The employee has the following limitations or restrictions:

Frequency	Never	Occasionally	Frequently	Constantly	Activity	Yes	No
<i>Hours/day</i>	<i>0 hrs.</i>	<i>Up to 3 hrs</i>	<i>3-6 hrs.</i>	<i>6 - 8 hrs.</i>	Dangerous machinery OK?		
Waist-bend/Twist					Wound-clean and dry		

ADA Physician Information – RSK – F204C
Sacramento City Unified School District

Would the employee pose a “direct threat” to the health or safety of either the patient/employee or others in the work place? Yes _____ No _____. Such as posing an imminent and substantial degree of risk either to the patient’s /employee’s own health or safety or to the health or safety of others)?

Date

Physician’s/Psychologist’s Signature

(Please type or print name)

Please return completed packet to:

SCUSD: Office of u05 Tw 25.335 0 Bnnl4s935 0