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**
Hours/day	*0 hrs.*	*Up to 3 hrs*	*3-6 hrs.*	*6 - 8 hrs.*	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 u0 5 Tw 25.335 0 0 Bnnl4s935 0