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? ________________________

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How long is this impairment expected to last:________________________________

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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		

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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 u25 Tw 25.335 0 Bnnl4s935 0