

**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:

<b>Frequency</b>	<b>Never</b>	<b>Occasionally</b>	<b>Frequently</b>	<b>Constantly</b>	<b>Activity</b>	<b>Yes</b>	<b>No</b>
<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