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:					
<u> </u>					
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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patient/employee or others in the w	t threat" to the health or safety of either the work place? Yes No Such as posing e of risk either to the patient's /employee's own safety of others)?			
Date	Physician's/Psychologist's Signature			
	(Please type or print name)			
Please return completed packet to:	SCUSD: Office of u@5 Tw 25.335 @ Bnnl4s935 @			