



CITY OF SACRAMENTO

REQUEST FOR MEDICAL INFORMATION FOR
REASONABLE ACCOMMODATION

DATE: _____

TO: _____
(Physician or Medical Provider)

FROM: _____
(ADA Coordinator)

SUBJECT: **REQUEST FOR MEDICAL INFORMATION NEEDED TO ASSIST IN PROVIDING A REASONABLE ACCOMMODATION FOR:**

(Applicant/Employee/Participant)

(Medical Record #)

(Social Security #)

The City of Sacramento is attempting to provide reasonable accommodation to the Applicant/Employee/Participant indicated above to assist in providing employment or participation in a program, activity or service. The information requested below is confidential and will only be used to determine the specific equipment and/or services necessary to accommodate the identified limitations due to the verified disability.

Under the Americans with Disabilities Act, an ***individual with a disability*** is a person who:

- Has a physical or mental impairment that substantially limits one or more major life activities (major life activity may include walking, breathing, speaking, performing manual task, seeing, hearing, learning, caring for oneself, sitting, standing, lifting, or reading);
- Has a record of such an impairment; or
- Is regarded as having such an impairment.

Please take the above definition into consideration and answer the following questions with respect to Applicant/Employee/Participant's request for reasonable accommodation:

1. Does the individual have an impairment that limits a major life activity? YES NO

If yes, please see the reverse side of this form to describe the limitation.

2. Is the disability permanent? YES NO Length of anticipated duration _____

3. From the enclosed job description, specify the job duty that the employee cannot perform _____

4. How does the limitation(s), impair the ability of the Applicant/Employee/Participant to perform the job duty described above?

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PHYSICIAN'S SIGNATURE	DATE	PHONE

Instructions: Complete this side of the form only if the answer to question #1 is yes.

<i>EMPLOYEE NAME</i>	<i>SOCIAL SECURITY NUMBER</i>
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Work Restrictions: Patient is restricted from or limited in performing the following functions (check activity and enter limitation, i.e.: 0 hours; 1-2 hours, 2-5 hours; 6-8 hours; or other notation);

<input type="checkbox"/> KEYBOARD USE/REPETITIVE USE OF HANDS	<input type="checkbox"/> GRASP/FINE FINGER MOTIONS
<input type="checkbox"/> SIT	<input type="checkbox"/> REPETITIVE USE OF FOOT CONTROLS
<input type="checkbox"/> STAND	<input type="checkbox"/> WALK
<input type="checkbox"/> SQUAT/KNEEL	<input type="checkbox"/> TWISTING (NECK/WAIST)
<input type="checkbox"/> BEND/STOOP	<input type="checkbox"/> CLIMB LADDERS/CLIMB STAIRS
<input type="checkbox"/> PUSH/PULL	<input type="checkbox"/> REACHING (Above and below shoulders)
<input type="checkbox"/> LIFT (Please specify lifting restriction)	
<input type="checkbox"/> CARRY (Please specify carrying restriction)	
<input type="checkbox"/> OTHER	

Describe any restrictions which may apply to the following:

<input type="checkbox"/> VISION
<input type="checkbox"/> HEARING
<input type="checkbox"/> MENTAL/EMOTIONAL
<input type="checkbox"/> OTHER (Sleeping, Speaking)