

## Introduction

In keeping with Governing Board policy, the district will comply with all federal, state and local laws and regulations requiring the accommodation of disabled employees and job applicants in the workplace.

Terms used in this Administrative Regulation, and documents, processes, and procedures that are developed, implemented or used in conjunction with the requirements of this Administrative Regulation, shall have the same definition and meaning as the governing laws and regulations. If the governing laws and regulations have differing or conflicting definitions or meanings, the broadest or most inclusive definition or meaning will be applied by the district.

The Director of Risk Management ("Coordinator") shall supervise: (a) the district's review, evaluation, and response to disability accommodation requests, (b) compliance with legal requirements to advise employees and job applicants of their disability accommodation rights, and (c) the development and implementation of appropriate training for district employees to ensure that governing laws, and district policy, are followed with respect to disability accommodation requests. The Coordinator may obtain assistance in completing these tasks. However, the Coordinator shall personally issue Written Determinations required under this Administrative Regulation. Before issuing such Written Determinations, the Coordinator will ensure that applicable laws and district policies have been followed.

The Coordinator shall be promptly notified of all requests for accommodation of an actual, potential or perceived disability, whether physical, mental, or emotional in nature. No district

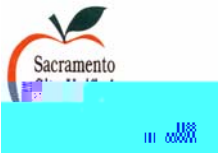




To commence the review process, which will be considered a required internal administrative remedy, the employee or job applicant must deliver a written Request for Review to the Associate Superintendent of Human Resources ("Reviewer"). While the Request need not be submitted on a particular form or in a particular format, it must contain a brief statement of the reason for the review and the requested remedy or action.

The Reviewer will review the documents and information developed during the Interactive Process and issue a Written Determination on Review. The Reviewer may grant or reject the requested relief or direct that further action be taken by the district to address the issues raised in





Request for Disability Accommodation  
Sacramento City Unified School District – RSK – F204 A

Completion of this form is not a requirement before the District will consider your accommodation request. However, completion may help the District quickly evaluate and/or respond to your request. Please also carefully read The Important Notice on the next page.

Employee/Applicant Name

Request for Disability Accommodation  
Sacramento City Unified School District – RSK – F204 A

IMPORTANT NOTICE

Sacramento City Unified School District complies with all federal, state and local laws and regulations regarding the accommodation in the workplace of disabled employees and job applicants. In response to your request for accommodation, an Interactive Process has begun in which you and the District will informally exchange information and ideas that will help the District determine (a) whether you are “disabled” within the applicable laws, and (b) whether you can complete the essential functions of application process/your current position, with or without accommodation, and (c) if accommodation is needed, the potential existence of reasonable accommodations that would not unduly burden the District.

For the Interactive Process to be successful, your personal and conscientious involvement in process is necessary. You will need to discuss your request with District representatives. You may also be requested to provide authorizations allowing the District to obtain medical and health information, including copies of medical or health records, and to speak with treating medical or health care providers. You might also be called upon to participate in examinations or reviews by health care providers or other consultants retained by the District at its expense. The District will use such information to best understand your request and determine what action the District should take in response to your request. This information will be reviewed only by District employees or its consultants directly involved in the review of your request. Upon your request, you may also review such information, which will be maintained in a separate Accommodation Request File. At your expense, you may also obtain copies of documents received by the District.

Your participation in this process is not a guarantee of employment or continued employment, nor does it alter or enlarge your rights under existing laws and/or collective bargaining agreements. The District also does not guarantee that your preferred accommodation will be granted. However, failure to participate in the Interactive Process, to assist in the gaining of needed information, may result in the District being unable to take action on your request.

At the completion of the Interactive Process, the District will provide you with its Written Determination. If you disagree with the Written Determination, or if during the Interactive Process you believe the District is not timely and in good faith acting upon your request, you may seek review of your concerns by filing a written Request for Review with the Associate Superintendent of Human Resources.

Further information regarding this process, and the District’s obligations in response to your request, can be found in Administrative Regulation 4032 which is available on request or through the District’s website. While the District strives to be responsive to issues raised by its employees and job applicants, additional information regarding your rights and obligations is also available from the Department of Fair Em

EMPLOYEE MEDICAL RELEASE FORM  
Sacramento City Unified School District – RSK – F204B

Sacramento City Unified School District  
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize my attending physician to release to my employer, Sacramento City Unified School District ("District"), the medical and psychological information described below.

This authorization is limited to the following types of information: information regarding my physical or psychological condition and my ability to safely perform my job task(s), including medical history, findings, x-rays, EKGs, laboratory studies, diagnosis, psychological or psychiatric evaluations, testing results and reports, treatment and recommendations.

This authorization is limited to the following uses of the information released: the purpose of the information is to assist the District in its determination of whether I am able to perform safely all the essential functions of the job, whether I would require accommodation, and if so, what types of accommodation are reasonable, determine my labor or psychological status and history in order to comply with any applicable requirements relating to accommodating disabilities and or providing a safe work environment.

I consent to and authorize the District to arrange for any additional examination of my condition by a different health practitioner, at District expense; such examination shall be job related and consistent with the purposes set forth in this release. I release the District from any claims, damages or liabilities of any kind which may arise from the medical examination.

I also authorize my employer, Sacramento City Unified School District, to release to the examining physician or psychologist, any and all information, including confidential personnel or medical information, which would be relevant to my physical or psychological condition and my ability to safely perform my job task.

This authorization shall remain valid until six months after the date I have executed this release of medical information.

\_\_\_\_\_  
Employee Name (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Signature

ATTENDING PHYSICIAN:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_



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

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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 u10025 Tw 25.335 02 1Bnnl4s935 02