



PACEAPP

PROFESSIONAL ASSOCIATION FOR CHILDHOOD EDUCATION
ALTERNATIVE PAYMENT PROGRAM SINCE 1976
Improving the Quality of Life for Families and Children

STATEMENT OF INCAPACITY

(Parent or Caretaker)

I, _____, authorize the release of the following information to PACEAPP.

Signature of Parent or Caretaker

In order for the child(ren) of this parent to be eligible to receive child care services, this form must be completed by a licensed professional specifying the medical reason child care is needed.

Instructions

- Every question on this document must be completed for this form to be valid.
- The duration of the medical incapacitation must be specified with a beginning and an ending date below.
- Please return this completed form to the address below within 5 days.

To be completed by physician:

1) Please state the nature of the incapacity (Attach a separate sheet, if necessary):

2) Probable dates of incapacity: From ____ / ____ / ____ To ____ / ____ / ____

3) Does the nature of the incapacitation prevent the parent from caring for the child without assistance for at least some part of the day? Yes No

4) Indicate in the boxes below the number of child care hours necessary each day:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

5) Is hospitalization required at this time? Yes No

Comments (Attach a separate sheet, if necessary):

Physician's or Clinician's Information:

Print Name

Position Title

Address

Signature

Date

Phone