

# GENERAL McLANE SCHOOL DISTRICT

## PHYSICIAN'S CERTIFICATE OF INCAPACITATION

PATIENT'S NAME \_\_\_\_\_

1. Nature of illness which rendered the employee unable to perform his or her duties (Incapacitated):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Specific period of time during which the employee was unable to perform his or her duties:

Incapacitated  
from: \_\_\_\_\_  
Month Day Year

to: \_\_\_\_\_  
Month Day Year

3. Date or dates of treatment and/or examinations(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. The above information is true to the best of my professional knowledge.

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Typed Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Degree or Major Field of Practice

\_\_\_\_\_  
Date

RETURN TO: General McLane School District  
11771 Edinboro Road  
Edinboro, PA 16412