

**CERTIFICATE OF PHYSICIAN, PSYCHOLOGIST OR
LICENSED CLINICAL SOCIAL WORKER**

NOTE: This certificate will be used in legal proceeding to appoint a guardian for the patient named below. This information it contains must be based on your personal examination of the patient. Please address each issue contained in the certificate including the *nature, cause, extent and probable duration* of any disability that your patient may have which interferes with his/her ability to make responsible decisions about health care, food, clothing, shelter or property. It is possible that your testimony about this information may be required at a hearing. Thank you for your concern and cooperation.

PATIENT'S NAME: _____

ADDRESS: _____

I, _____, located at _____,
(provider's name) (address)

_____, am a _____ graduate of _____.
(telephone number) (year) (school)

I am licensed to practice medicine/psychology/social work (circle one) in the United States in the following states: _____.

I am Board Certified in _____. My specialty is _____.

I have known this patient for _____.
(period of time)

The history of my involvement with the patient is the following

_____.

I personally examined _____ on _____, 200__.
(patient's name)

The examination lasted approximately _____.
(time)

I performed or ordered the following tests: _____

The patient exhibited the following symptoms:

Physical: _____

Mental: _____

Based on tests and my examination of the patient, it is my professional opinion that s/he:

- does have** a physical or mental disability that interferes with the ability to make or communicate responsible decisions regarding health care, food, clothing, shelter or the administration of property.

- does not have** a physical or mental disability that interferes with the ability to make or communicate responsible decisions regarding health care, food, clothing, shelter or administration of property.

That disability is diagnosed as: _____.

The **nature** of the disability is: _____.

The **cause** of the disability is: _____.

The **extent** of the disability is: _____.

The **probable duration** of the disability is: _____.

The **usual treatments** for the disability are: _____.

The patient **retains the ability** to perform the following functions: _____

The patient **does** **does not** require institutional care.

- In my opinion, the patient has a disability that prevents him/her from making or communicating **any** responsible decisions concerning his/her **person**.
- In my opinion, the patient has a disability which prevents him/her from making or communicating **some** responsible decisions concerning his/her **person**. The patient is able to decide: _____.
- In my opinion, the patient has a disability which prevents him/her from making or communicating **any** responsible decisions concerning his/her **property**.
- In my opinion, the patient has a disability which prevents him/her from making or communicating **some** responsible decisions concerning his/her **property**. The patient is able to decide: _____.
- In my opinion, the patient **does have** sufficient mental capacity to understand the nature of a guardianship and **can** consent to the appointment of a guardian.
- In my opinion, the patient **does not have** sufficient mental capacity to understand the nature of a guardianship and **cannot** consent to the appointment of a guardian.

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of the foregoing certification are true.

Date

Provider's Signature

(Printed name)