

**PHYSICIAN'S or PSYCHOLOGIST'S CERTIFICATE**

**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 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: \_\_\_\_\_

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The patient exhibited the following symptoms:

Physical: \_\_\_\_\_

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Mental: \_\_\_\_\_

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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: \_\_\_\_\_

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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)