

Certification of Examining Professional

Name: _____

Address: _____

Telephone: _____

In the Matter of: (Insert the incapacitated person's name)

_____,

an Incapacitated Person.

I, _____, of full age, hereby certify as follows:

1. This certification is made by me for purposes of the periodic report of the well-being of _____, an incapacitated person.

[insert the incapacitated person's name]

2. I examined _____, on _____. The examination took place at _____.

[insert the incapacitated person's name]

[insert date]

My examination revealed that (select one)

- ☐ the condition of the incapacitated person is essentially unchanged;
☐ during the reporting period, the condition of the incapacitated person has changed as follows:

3. In my opinion, _____,

[insert the incapacitated person's name]

- ☐ continues to lack capacity to govern him/herself and to manage his/her affairs to the same extent and therefore the guardianship should continue unchanged;

- ☐ exhibits a change in capacity such that the guardianship should be modified as follows:

I hereby certify and say that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

Date

Signature of Professional

Print Name