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