CIRCUIT COURT FOR _____ (City/County) ☐, **MARYLAND**

Located at _____ (Court Address) **Case No.** _____

In the Matter of

_____ (Name of Alleged Disabled Person) _____ (Docket reference)

PHYSICIAN'S CERTIFICATE
(Md. Rule 10-202(a))

NOTE TO PHYSICIAN: A petitioner will use this certificate in a legal proceeding to request a guardian for the patient named below. The petitioner must submit the original certificate. Your answers must be specific and detailed and based on your personal examination or evaluation of the patient. Address each issue contained in the certificate that may interfere with the patient's ability to make responsible decisions about health care, food, clothing, shelter, or property. You may complete the form yourself or have another person fill it out under your supervision. You must sign the certificate. Your testimony about its contents may be required at a hearing. Attach additional sheets, if necessary.

PATIENT'S NAME: _____

PATIENT'S ADDRESS: _____

PATIENT'S DATE OF BIRTH: _____ PATIENT'S SEX: _____

I, _____ (Physician's Name), employed by _____ (Employer),
am a _____ (Year) graduate of _____
School of Medicine. I am licensed to practice medicine in the United States in the following state(s):

_____. My license number is: _____

The following knowledge, training, board certification/eligibility, or experience qualifies me to examine/evaluate the patient's functional capacity to make or communicate responsible decisions concerning their person (health care, food, clothing, shelter, etc.) or to manage their property or financial affairs:

I have known this patient for _____ (Length of Time). My history of involvement with the patient is as follows:

EXAMINATION/EVALUATION AND DIAGNOSIS

I personally examined/evaluated the above-named patient (select all that apply):

☐ in person at (select all that apply):

☐ a hospital/medical office/other facility, _____ (Facility name), on _____ (Date(s)).

☐ at the patient's residence on _____ (Date(s)).

☐ other location: _____ (Description), located at _____ (Address), on _____ (Date(s)).

☐ remotely, with audio and visual access to the patient, using _____ (Platform), on _____ (Date(s)). I did not meet with the patient in person because _____

The following individual(s) assisted the patient with the virtual examination/evaluation.

Full Name	Title/Relationship	Phone Number	Email (if any)

The most recent examination/evaluation lasted approximately _____ (Length of Time). I performed or ordered the following tests and/or procedures: _____

I communicated with the patient in the following manner:

☐ English

☐ Other language: _____

☐ Other means: _____ (Describe)

Upon examination/evaluation of the patient, I report the following findings:

PHYSICAL AND MENTAL CONDITIONS

Physical conditions

☐ None

☐ The patient has the following physical diagnoses:

Overall physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Explain:

Overall physical health will: ☐ Improve ☐ Be stable ☐ Decline ☐ Uncertain
Explain:

Mental conditions

☐ None

☐ The patient has the following mental (DSM-5) diagnoses (attach additional sheets if needed):

Diagnostic Code	Description
	☐ Mild ☐ Moderate ☐ Severe
	☐ Mild ☐ Moderate ☐ Severe
	☐ Mild ☐ Moderate ☐ Severe

Overall mental health will: ☐ Improve* ☐ Be stable ☐ Decline ☐ Uncertain

*If improvement is possible, the individual should be re-examined/re-evaluated in _____ weeks.

The mental diagnosis/diagnoses affect functioning as follows:

Do temporary causes of mental impairment exist? ☐ Yes ☐ No ☐ Uncertain
If yes, have they been evaluated and treated? ☐ Yes ☐ No Explain:

Do reversible causes of mental impairment exist? ☐ Yes ☐ No ☐ Uncertain
If yes, have they been evaluated and treated? ☐ Yes ☐ No Explain:

List all medications:

Name	Purpose	Dosage/Schedule

Reversible or temporary somatic factors

Are there factors (hearing, vision or speech impairment, etc.) that incapacitate the patient that could improve with time, treatment, or assistive devices?

☐ Yes ☐ No ☐ Uncertain

Explain:

COGNITIVE FUNCTION

Alertness/level of consciousness

Overall impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Non-responsive

Describe below or ☐ in attachment

Memory, cognitive, and executive functioning

Overall impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Non-responsive

Describe below or ☐ in attachment

Fluctuation

Symptoms vary in frequency, severity, or duration: ☐ Yes ☐ No ☐ Uncertain

Describe below or ☐ in attachment

EVERYDAY FUNCTIONING

The patient **is capable** of performing the Instrumental Activities of Daily Living (IADLs) (select all that apply):

☐ Managing finances effectively (select one): ☐ without assistance ☐ with assistance, specifically:

☐ Managing transportation needs (select one): ☐ without assistance ☐ with assistance, specifically:

☐ Managing communication (e.g., telephone and mail) (select one): ☐ without assistance ☐ with assistance, specifically:

☐ Managing medication (select one): ☐ without assistance ☐ with assistance, specifically:

☐ Other executive functions (describe):

The patient **is capable** of participating in the following civil or legal matters (select all that apply):

☐ Signing documents
☐ Retaining legal counsel
☐ Participating in legal proceedings
☐ Other (describe):

INSTITUTIONAL CARE

The patient (select one):

☐ **does** require institutional care.
☐ **does not** require institutional care.
☐ can reside in the community with appropriate support, specifically:

NEED FOR GUARDIANSHIP OF THE PERSON

(Select one):

☐ In my professional opinion, within a reasonable degree of medical certainty, the patient (**select one**) ☐ **does** ☐ **does not** have a disability that prevents them from making or communicating **any** responsible decisions concerning their **person**.

☐ In my professional opinion, within a reasonable degree of medical certainty, the patient has a disability that prevents them from making or communicating **some** responsible decisions concerning their **person**. Specifically, the patient is able to make decisions regarding:

but is unable to make decisions regarding:

.....

.....

.....

NEED FOR GUARDIANSHIP OF THE PROPERTY

(Select one):

☐ In my professional opinion, within a reasonable degree of medical certainty, the patient (**select one**) ☐ **does** ☐ **does not** have a disability that prevents them from making or communicating **any** responsible decisions concerning their **property** and has a demonstrated inability to manage their **property** and affairs effectively because of physical or mental disability.

☐ In my professional opinion, within a reasonable degree of medical certainty, the patient has a disability that prevents them from making or communicating **some** responsible decisions concerning their **property**. Specifically, the patient is able to make decisions regarding:

.....

.....

.....

but is unable to make decisions regarding:

.....

.....

.....

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

.....
Date

.....
Physician's Signature

.....
Printed Name

.....
Address

.....
City, State, Zip

.....
Telephone

.....
E-mail

Reset