AFFIDAVIT OF MEDICAL DOCTOR
REGARDING PATIENT INCAPACITY

State of _____
County of _____

I, _____, (name of physician), being first duly sworn, depose and say:

1. I am a practicing physician licensed by _____ (name of state) as a medical doctor, and specialize in _____ (family medicine, etc.).

2. On date _____, 20____, I completed a physical and mental examination of _____, Patient, at the request of _____ (family member, interested party, etc.)

3. As a result of said examination, it is my professional opinion as a practicing physician, licensed as a medical doctor, that the said Patient:

   [ ] is, by reason of advanced age, physical incapacity, or mental weakness, incapable of managing his/her own estate.

   [ ] lacks the mental capacity to enter a binding agreement or to make decisions on his/her own behalf.

   [ ] does not have the ability to understand that a contract is being made and its general nature.

4. Additional information: _____
   _____

5. I certify that all the facts and opinions stated in this affidavit are true and correct to the best of my knowledge and belief, under penalty of perjury.

_____ _____
Printed name of physician Signature of physician

Signed and sworn to (or affirmed) before me on _____, 20 ____ by _____.

_____ [Stamp]
Notary Public
My commission expires: _____