

INDIANA PHYSICIAN'S REPORT

I, _____, a physician holding an unlimited
(Name of Physician)
license to practice medicine in the State of Indiana, hereby submits the following
report on _____, hereafter referred to as
(Name of Patient)
the "Patient", based upon my professional examination of the Patient.

1. Dates of all examinations of the Patient within the past twelve (12) months from the date hereof.

2. In your opinion, based upon your examination(s) and observation(s) of the Patient, is the Patient incapacitated? If so, please describe the nature and type of incapacity.

3. In your opinion, based upon your examination(s) and observation(s) of the Patient, how long has the Patient been incapacitated?

4. Describe the Patient's mental and physical condition and, if appropriate, describe the Patient's educational condition, adaptive behavior and social skills.

5. In your opinion, is the Patient totally or partially incapable of making personal and financial decisions? If the Patient is partially incapable, please list the kinds of decisions which the Patient can and cannot make. Include the reason(s) for this opinion.

6. In your opinion, what is the most appropriate living arrangement for the Patient and, if applicable, please describe the most appropriate treatment or rehabilitation plan. Include the reason(s) for your opinion.

7. Is the Patient able to appear in Court without injury to his / her health?

_____ Yes _____ No

If the answer is no, explain the medical reason(s) for your answer.

8. Is the Patient capable of consenting to the appointment of a Guardian?

_____ Yes _____ No

9. Is the nature of the Patient's incapacity such that it prevents him / her from making a knowing and voluntary Waiver of Notice?

_____ Yes _____ No

10. In your opinion, is a Guardian needed to care for the Patient?

_____ Yes _____ No

If a Guardian is needed, is one needed for either personal or financial needs only or for both needs?

_____ Personal _____ Financial _____ Both

AFFIRMATION

I, _____, affirm, under the penalties of
(Name of Physician)
perjury, that the above and foregoing is true and correct to the best of my
knowledge and belief.

Signed: _____

Name: _____

Address: _____

Telephone No.: _____

Indiana Medical License No.: _____

Dated: _____

NOTARY

Subscribed and sworn to before me, a Notary Public, in and for said County and State,
this _____ day of _____, 200__.

Notary Public

Resident of _____ County

My Commission Expires:

SUPPLEMENTAL EVALUATIONS

If the description of the Patient's mental, physical and educational condition, adaptive behavior or social skills is based on evaluations completed by other professionals, please provide the names and addresses of those professionals and any other professionals who are able to provide additional evaluations.

Evaluations on which the report is based must have been performed within twelve (12) months of the date of the filing of the Petition.

Names and addresses of other professionals who performed evaluations upon which this report is based:

Name: _____

Address: _____

Tele: _____

Name: _____

Address: _____

Tele: _____

Name: _____

Address: _____

Tele: _____

Name: _____

Address: _____

Tele: _____