STATE OF INDIANA	**)**	**KOSCIUSKO SUPERIOR COURT 1**
COUNTY OF KOSCIUSKO	**)**	
	)	**CAUSE NO. _____**
IN RE: THE GUARDIANSHIP OF	**)**	
	)	
	)	
_____	**)**	**PHYSICIAN'S REPORT**

PROTECTED PERSON

_____ , a Physician holding an unlimited license to practice medicine in the State of Indiana, submits the following report on _____, ("Patient"), based upon examination of the Patient.

1. Set forth the dates of all examinations of the Patient within the last (1) year from the date of this report.

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

3. In your opinion, based upon your examination and observation 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 only partially incapable of making personal and financial decisions; and, if the latter, the kinds of decisions which the Patient can and cannot make. (Include the reason for this opinion.)

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

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

[ ] Yes
[ ] No

If the answer is no, explain the medical reasons for your answers.

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 the Patient 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

11. If a Guardian is needed, is one needed for personal or financial need, or both?

[ ] Personal
[ ] Financial

I affirm under the penalties for perjury that the foregoing representations are true.

Dated this _____ day of _____ , 20 _____ .

Physician's Signature:_____

Printed Name: _____

Address: _____

Telephone: _____

If the description of the Patient's mental, physical and educational condition, adaptive behavior or social skills is based on evaluations by other professional, pleas provide the names and addresses of all professionals who are able to provide additional evaluations. Evaluations on which the report is based should have been performed within three (3) months of the date of the filing of the Petition.

Name and addresses of the other persons who performed evaluations upon which this Report is based;

Name (s): _____

Address (s): _____

Telephone (s): _____

IC 29-1-1-19