

INCAPACITATION STATEMENT

RE:

Name (Please Print)

Date of Birth

Address

I have personally examined _____, and in my opinion, he/she is incapacitated to receive and evaluate information effectively or communicate decisions, to such an extent that he/she lacks capacity to manage health care decisions.

Health care decisions means informed decisions in which this individual exercises his/her right to accept, maintain, discontinue, or refuse any care, treatment, service, or procedure to maintain diagnosis, or treat his/her physical or mental condition.

1.

Physician (Please Print)

Date

Physician (Signature)

Date

2.

Physician (Please Print)

Date

Physician (Signature)

Date

OR

3.

Psychologist (Please Print)

Date

Psychologist (Signature)

Date