

Your Name: _____
Address: _____
City, State, Zip _____
Telephone: _____
Email Address: _____
Self-Represented

DISTRICT COURT
_____ **COUNTY, NEVADA**

In the Matter of the Guardianship of the:

- Person
- Estate
- Person and Estate

CASE NO.: _____

DEPT: _____

of:

(*name of adult who needs a guardian*)
A Proposed Protected Person.

**PHYSICIAN'S CERTIFICATE OF INCAPACITY AND
REGARDING THE NEED FOR GUARDIANSHIP**

In accordance with NRS 159.044(2)(j):

I, (*name of person completing this form*), _____
am:

- A physician or psychiatrist licensed to practice in the State of Nevada.
- A physician or psychiatrist employed by the Department of Veterans Affairs.
- Providing a letter signed by a governmental agency in the State of Nevada which conducts investigations.
- Employed by (*name of agency*) _____

The title of my position is (*job title*) _____
and I am qualified to execute this Certificate for the following reasons:

1. It is my opinion that the adult patient, (*name*) _____,
suffers from a diagnosis of: _____

2. It is my opinion that this patient (*check one*) is OR is not a danger to himself/herself
or to others.

3. It is my opinion that (*check one*):

- The patient is able to attend the guardianship Court hearing.
- The patient would not comprehend the reason for the Court hearing or be able to contribute to the proceeding.
- Attending the Court hearing would be detrimental to the patient.

4. It is my opinion that this patient (*check one*):

- Is capable of living independently.
- Is capable of living independently with the following assistance (*explain*)

- Is not capable of living independently.

5. **In accordance with NRS 159.052(1)(a):**

It is my opinion that this patient is unable to respond (*check all that apply*):

- To an immediate need for medical attention
- To a substantial and immediate risk of physical harm
- To a substantial and immediate risk of financial loss
- None of the above

6. It is my opinion that this patient (*check one*):

- Is or has been subject to abuse, neglect or exploitation.
- Has not been subject to abuse, neglect or exploitation.

7. In accordance with NRS 159.044:

It is my opinion that this patient needs a guardian of the (*check one*):

- Person (only)
- Estate (only)
- Person and Estate

DATED this (*day*) _____ day of (*month*) _____, 20____.

(Signature of Physician or Individual Signing Form)

(Printed Name)