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 of: _________________________________ (*name of adult who needs a guardian*) A Proposed Protected Person.	CASE NO.: ____________________ DEPT: ____________________

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:
____
____
____

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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)