Power of Attorney for Health Care Statement of Incapacity

I have personally examined ______________________________ [patient’s name] and certify that the patient meets the statutory definition of incapacity, in that the patient is unable to receive and evaluate information effectively or to communicate decisions to such an extent that the patient lacks the capacity to manage his or her health care decisions.

I am not a relative of this patient and do not have knowledge that I am entitled to or have a claim on any portion of the patient's estate.

________________________________________
First Physician Signature

________________________________________
Print Name

_________________________ __________________________
Date Time

Second Signature [circle one] Physician OR Psychologist

________________________________________
Print Name

A COPY OF THIS STATEMENT MUST BE ATTACHED TO THE POWER OF ATTORNEY FOR HEALTH CARE

Power of Attorney for Health Care Statement of Regaining of Capacity

I have personally examined ______________________________ [patient’s name] and certify that the patient no longer meets the statutory definition of incapacity, in that the patient is again able to receive and evaluate information effectively or to communicate decisions to such an extent that the patient now possesses the capacity to manage his or her health care decisions.

I am not a relative of this patient and do not have knowledge that I am entitled to or have a claim on any portion of the patient's estate.

_________________________ __________________________
Signature [circle one] Physician Psychologist

________________________________________
Print Name

A COPY OF THIS STATEMENT MUST BE ATTACHED TO THE POWER OF ATTORNEY FOR HEALTH CARE