CIRCUIT COURT FOR _____ **, MARYLAND**
City/County

Located at _____ Telephone _____
Court Address

In the Matter of Case No. _____

_____ _____
Name of Alleged Disabled Person Docket Reference

NURSE PRACTITIONER'S CERTIFICATE
(Md. Rule 10-202(a))

NOTE TO NURSE PRACTITIONER: A petitioner will use this certificate in a legal proceeding to request a guardian for the patient named below. The petitioner must submit the original certificate. Your answers must be specific and detailed and based on your personal examination or evaluation of the patient. Address each issue contained in the certificate that may interfere with the patient's ability to make responsible decisions about health care, food, clothing, shelter, or property. You may complete the form yourself or have another person fill it out under your supervision. You must sign the certificate. Your testimony about its contents may be required at a hearing. Attach additional sheets, if necessary.

PATIENT'S NAME: _____

PATIENT'S ADDRESS: _____

PATIENT'S DATE OF BIRTH: _____ PATIENT'S GENDER: _____

I, _____, employed by _____,
Nurse Practitioner's Name Employer

am a _____ graduate of _____.
Year School

I am licensed in the United States in the following state(s): _____.

My license number is _____. My certification/specialty is _____

The following knowledge, training, or experience qualifies me to examine/evaluate the patient's functional capacity to make or communicate responsible decisions concerning their person (health care, food, clothing, shelter, etc.) or to manage their property or financial affairs:

I have known this patient for _____. My history of involvement with the patient is as follows:
Length of Time

EXAMINATION/EVALUATION AND DIAGNOSIS

I personally examined/evaluated the above-named patient (select all that apply):

☐ in person at (select all that apply):

☐ a hospital/professional office/other facility, _____ (Facility name), on _____ (Date(s)).

☐ at the patient's residence on _____ (Date(s)).

☐ other location: _____ (Description), located at _____ (Address), on _____ (Date(s)).

☐ remotely, with audio and visual access to the patient, using _____ (Platform), on _____ (Date(s)). I did not meet with the patient in person because _____

_____

_____

The following individual(s) assisted the patient with the virtual examination/evaluation.

Full Name	Title/Relationship	Phone Number	E-mail (if any)

The most recent examination/evaluation lasted approximately _____ (Length of Time). I performed or ordered the following tests and/or procedures: _____

_____

_____

I communicated with the patient in the following manner:

☐ English

☐ Other language: _____

☐ Other means: _____ (Describe)

Upon examination/evaluation of the patient, I report the following findings:

PHYSICAL AND MENTAL CONDITIONS

Physical conditions

☐ None

☐ The patient has the following physical diagnoses:

_____

_____

Overall physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Explain:

Overall physical health will: ☐ Improve ☐ Be stable ☐ Decline ☐ Uncertain
Explain:

Mental conditions

☐ None
☐ The patient has the following mental (DSM-5) diagnoses (attach additional sheets if needed):

Diagnostic Code	Description
	☐ Mild ☐ Moderate ☐ Severe
	☐ Mild ☐ Moderate ☐ Severe
	☐ Mild ☐ Moderate ☐ Severe

Overall mental health will: ☐ Improve* ☐ Be stable ☐ Decline ☐ Uncertain

*If improvement is possible, the individual should be re-examined/re-evaluated in _____ weeks.

The mental diagnosis/diagnoses affect functioning as follows:

Do temporary causes of mental impairment exist? ☐ Yes ☐ No ☐ Uncertain
If yes, have they been examined or evaluated and treated? ☐ Yes ☐ No Explain:

Do reversible causes of mental impairment exist? ☐ Yes ☐ No ☐ Uncertain
If yes, have they been examined or evaluated and treated? ☐ Yes ☐ No Explain:

List all medications:

Name	Purpose	Dosage/Schedule

Reversible or temporary somatic factors
Are there factors (hearing, vision or speech impairment, etc.) that incapacitate the patient that could improve with time, treatment, or assistive devices?
☐ Yes ☐ No ☐ Uncertain
Explain:

COGNITIVE FUNCTION

Alertness/level of consciousness
Overall impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Non-responsive
Describe below or ☐ in attachment

Memory, cognitive, and executive functioning
Overall impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Non-responsive
Describe below or ☐ in attachment

Fluctuation
Symptoms vary in frequency, severity, or duration: ☐ Yes ☐ No ☐ Uncertain
Describe below or ☐ in attachment

EVERYDAY FUNCTIONING

The patient **is capable** of performing the Instrumental Activities of Daily Living (IADLs) (select all that apply):

☐ Managing finances effectively (select one): ☐ without assistance ☐ with assistance, specifically: _____

☐ Managing transportation needs (select one): ☐ without assistance ☐ with assistance, specifically: _____

☐ Managing communication (e.g., telephone and mail) (select one): ☐ without assistance ☐ with assistance, specifically: _____

☐ Managing medication (select one): ☐without assistance ☐with assistance, specifically: _____

☐ Other executive functions (describe): _____

The patient **is capable** of participating in the following civil or legal matters (select all that apply):

☐ Signing documents
☐ Retaining legal counsel
☐ Participating in legal proceedings
☐ Other (describe):

INSTITUTIONAL CARE

The patient (select one):

☐ **does** require institutional care.
☐ **does not** require institutional care.
☐ can reside in the community with appropriate support, specifically:

NEED FOR GUARDIANSHIP OF THE PERSON

(Select One):

☐ In my professional opinion and based on my personal examination/evaluation, it is more likely than not that the patient (**select one**) ☐ **does** ☐ **does not** have a disability that prevents them from making or communicating **any** responsible decisions concerning their **person**.

☐ In my professional opinion and based on my personal examination/evaluation, it is more likely than not that the patient has a disability that prevents them from making or communicating **some** responsible decisions concerning their **person**. Specifically, the patient is able to make decisions regarding:

but is unable to make decisions regarding:

.....

.....

.....

NEED FOR GUARDIANSHIP OF THE PROPERTY

(Select one):

☐ In my professional opinion and based on my personal examination/evaluation, it is more likely than not that the patient (**select one**) ☐ **does** ☐ **does not** have a disability that prevents them from making or communicating **any** responsible decisions concerning their **property** and has a demonstrated inability to manage their **property** and affairs effectively because of physical or mental disability.

☐ In my professional opinion and based on my personal examination/evaluation, it is more likely than not that the patient has a disability that prevents them from making or communicating **some** responsible decisions concerning their **property**. Specifically, the patient is able to make decisions regarding:

.....

.....

.....

but is unable to make decisions regarding:

.....

.....

.....

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of this document are true.

.....
Date

.....
Nurse Practitioner's Signature

.....
Printed Name

.....
Street Address

.....
City, State, Zip

.....
Telephone Number

.....
E-mail

.....
Fax