

MARYLAND CIRCUIT COURT FOR \_\_\_\_\_, MARYLAND  
 Located at \_\_\_\_\_ City/County \_\_\_\_\_  
JUDICIARY Court Address \_\_\_\_\_ Telephone \_\_\_\_\_  
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 \_\_\_\_\_ Length of Time \_\_\_\_\_. My history of involvement with the patient is as follows:

## **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, \_\_\_\_\_,

on \_\_\_\_\_.

Facility name

Date(s)

at the patient's residence on \_\_\_\_\_.

Date(s)

other location: \_\_\_\_\_, located at \_\_\_\_\_

Description

Address

, on \_\_\_\_\_

Date(s)

remotely, with audio and visual access to the patient, using \_\_\_\_\_,

Platform

on \_\_\_\_\_. I did not meet with the patient in person because \_\_\_\_\_

Date(s)

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 \_\_\_\_\_. I performed or ordered Length of Time  
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:

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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:

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### **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:

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

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Date

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Nurse Practitioner's Signature

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Printed Name

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Street Address

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City, State, Zip

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Telephone Number

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E-mail

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Fax