



CIRCUIT COURT FOR _____, MARYLAND

Located at _____ City/County _____ Telephone _____
Court Address _____ Case No. _____

In the Matter of _____

Name of Alleged Disabled Person

Docket Reference

**PETITION FOR APPOINTMENT OF HEALTH CARE PROFESSIONALS
(Md. Rule 10-202 (a)(3))**

NOTE: Use this form if you are asking the court for guardianship of an alleged disabled person who lives with or is under the control of someone who refuses to allow them to be examined or evaluated by health care professionals (physician, psychologist, licensed certified social worker-clinical, or nurse practitioner). File this form with the **Petition for Guardianship of Alleged Disabled Person (CC-GN-002)**. Attach any documents that support your request. The court may issue an order requiring the person who refuses to allow the alleged disabled person to be examined or evaluated to appear at a hearing and explain why the alleged disabled person should not be examined or evaluated. The court may also require the alleged disabled person to appear at that hearing.

I, _____, whose address is _____
Name
_____, and whose telephone number is _____,
and whose email address (if available) is _____, ask the court to appoint
two health care professionals to examine or evaluate _____ Name of alleged disabled person. I state that:

1. Along with this petition, I have filed a Petition for Guardianship of the Alleged Disabled Person of _____ with this court.
Name of alleged disabled person
2. _____ lives with or is under the control of _____,
Name of alleged disabled person Name
who has refused to allow _____ to be examined or evaluated by a
Name of alleged disabled person
health care professional. I made the following efforts to have the alleged person examined or evaluated:

3. _____ may be at risk unless a guardian is appointed. In
Name of alleged disabled person
addition to the concerns expressed in the Petition for Guardianship of Alleged Disabled person, I have the following other concerns:

Case No. _____

FOR THESE REASONS, I ask the court to:

1. Issue an order requiring _____
Name of person the alleged disabled person lives with or is under the control of
to appear and show cause why _____ should not be
Name of alleged disabled person
examined or evaluated.
2. Schedule a hearing as soon as possible.
3. Grant any other and further relief as may be required.

I solemnly affirm under the penalties of perjury that the contents of this document are true to the best of my knowledge, information, and belief.

Date

Street Address

City, State, Zip

E-mail

Signature

Printed Name

Telephone Number

Fax