MEDICAL CERTIFICATE AFFIDAVIT	Docket No.	Commonwealth of Massachusetts The Trial Court Probate and Family Court
The purpose of this affidavit is to obviate the need for a new medical certificate for patients who have been and continue to be medically stable as indicated on the most recently filed Medical Certificate, particularly Part I, A & B. This may not be used at the time of a permanent appointment unless counsel for the Incapacitated or Protected Person has been appointed and does not object to its use.		_____ Division

To the Honorable Justices of the Probate and Family Court:

The undersigned hereby certifies under the penalties of perjury that:

I am:

- ☐ a registered physician specializing in the area of: _____ .
- ☐ a licensed psychologist.
- ☐ a certified psychiatric nurse clinical specialist.
- ☐ a nurse practitioner with experience in the area of: _____ .

I personally examined: _____ (First Name) _____ (Middle Name) _____ (Last Name) _____ (age)

on _____ (Date(s) of Examination(s)) and reviewed the most recently filed medical certificate

dated _____ .

Based upon this examination and review, I certify that the prior diagnosis and statements regarding decision-making and functional abilities contained in the most recently filed medical certificate continue to be true and accurate and are incorporated and merged herein.

The individual is presently under my continuous care, with regular treatment and observation since _____ (date) .

There have been no significant changes in the individual's diagnoses, decision-making, or functional abilities in the interim period.

The individual has resided in the same setting and has had no acute medical admissions in the interim period or, if there has been a medical admission, this admission did not affect the individual's prior diagnosis, decision-making or functional abilities.

I hereby certify that the evaluation of diagnosis, cognition, and function is within the scope of my professional competence based upon my education, training, and experience. I further certify that this report is complete and accurate to the best of my information and belief.

Signed under the penalties of perjury:

_____ Date _____

SIGNATURE OF CLINICIAN

_____ _____

(Print name) License type, number, and date

Office Address: _____ (Address Line 1) _____ (Apt, Unit, No. etc.) _____ (City/Town) _____ (State) _____ (Zip)

Office Phone: _____

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