MEDICAL CERTIFICATE FOR TERMINATION OF ☐ GUARDIANSHIP AND/OR ☐ CONSERVATORSHIP	Docket No.	Commonwealth of Massachusetts The Trial Court Probate and Family Court

INSTRUCTIONS FOR COMPLETION

This document is to be used by the Probate and Family Court in the process of determining that a person under guardianship or conservatorship no longer meets the standard for establishing said guardianship or conservatorship. If, however, the termination is being sought for any other reason, do not use this document. Instead, the Medical Certificate Guardianship or Conservatorship form is required.

_____ **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 am prepared to present a statement of my qualifications to the Court by written affidavit or personal appearance if directed to do so.

I personally examined _____ (First Name) _____ (Middle Initial) _____ (Last Name)

(print name of incapacitated person or protected person)

who resides at _____ (Address) _____ (Apt, Unit, No. etc.) _____ (City/Town) _____ (State) _____ (Zip)

on _____ (Date)

- ☐ Who is under guardianship and no longer has a clinically diagnosed condition that results in an inability to receive and evaluate information or make or communicate decisions to such an extent that the individual lacks the ability to meet essential requirements for physical health, safety, or self-care.
- ☐ Who is under a conservatorship and
  - ☐ No longer has a clinically diagnosed impairment in the ability to receive and evaluate information or make or communicate decisions, and property will no longer be wasted or dissipated unless management is provided.
  - ☐ No longer has a clinically diagnosed impairment in the ability to receive and evaluate information or make or communicate decisions and protection is no longer necessary or desirable to obtain money for the support, care, and welfare of the person or those entitled to the person's support.

Prior to the examination, I informed the patient that communications with me would not be privileged:

☐ Yes.

☐ No, Explain:

DESCRIBE IN DETAIL THE CLINICAL AND FUNCTIONAL FINDINGS SUPPORTING THE DISCHARGE OF THE GUARDIANSHIP AND/OR CONSERVATORSHIP:

CERTIFICATIONS

This form was completed based on an in-person clinical evaluation of the individual who ☐ is ☐ is not a patient under my continuing care and treatment.

In addition to a clinical examination, other sources of information for this examinaton:

☐ Review of medical record;

☐ Discussion with health care professionals involved in the individual's care;

☐ Discussion with family or friends;

☐ Other.

Names and titles/relationships of those individuals who assisted in preparation of this report:

Name	Title/Relationships

click to add click to remove

List any tests which bear upon the issue of incapacity and date of tests:

Test	Date

click to add click to remove

This document must be signed and dated by the person completing it. It does not need to be notarized.

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

_____ _____
(Office Address) (Apt, Unit, No. etc.)

_____ _____ _____
(City/Town) (State) (Zip)

Office Phone #: _____

_____
License type, number, and date

Reset Form