

IN THE MATTER OF:

CASE NUMBER:

DOCTOR'S AFFIDAVIT REGARDING CAPACITY

PERSONALLY APPEARED BEFORE ME _____ who being duly sworn
deposes and says:

I am (Please set forth your medical credentials):

Business address and telephone:

Date and Place of this examination:

I have had previous opportunities to evaluate the patient. YES NO
(If yes, indicate dates and circumstances within the last year and/or reference if you have been the patient's personal
physician for a period of time and the time frame.)

Is the patient oriented to time and place? YES NO

What is the physical condition and age of the patient? (Detail any other significant factors that may be relevant to the
Court.)

Set forth the results of any tests which bear on the issue of incapacity and date of test:

BASED UPON MY EVALUATION OF THIS PATIENT:

I DO NOT believe this patient is an "incapacitated person".¹ I do not find any impairment by reason of mental illness,
mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause
to the extent that he/she lacks sufficient understanding or capacity to make or communicate responsible decisions
concerning his/her person, property, or finances.

I DO BELIEVE THIS PATIENT IS AN "INCAPACITATED PERSON" and in need of a Guardian and/or Conservator
as I find him/her to be impaired by reason of (CHECK ALL THAT APPLY AND SET OUT AND DESCRIBE THE
LIMITATIONS RESULTING FROM EACH.)

- Mental Illness
- Mental Deficiency
- Physical Illness or Disability
- Advanced Age
- Chronic Use of Drugs
- Chronic Intoxication
- Other

¹"Incapacitated person" means any person who is impaired by reason of mental illness, mental deficiency,
physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, or other cause to the extent that he
lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person or
property . (Section 62-5-101 of the South Carolina Code of Laws)

Is this condition permanent or temporary? _____

Can Patient perform activities of daily living? _____

What other information do you believe would assist the Court in making a determination of capacity? _____

FURTHER AFFIEANT SAYETH NOT.

Physician's Signature: _____

Print Name: _____

Examiner: _____
(Credentials (M.D., Ph.D., D.O., R.N.))

Address: _____

Telephone: _____

SWORN to before me this _____ day of
_____, 20____

Notary Public of South Carolina
My commission expires: _____

FAILURE TO PROVIDE DETAILED RESPONSES TO THE QUESTIONS ON THIS AFFIDAVIT MAY OBLIGATE YOU TO APPEAR AT THE PROBATE COURT HEARING.

All information MUST be typed or clearly printed.