Medical Declaration/Certification
Regarding Need for Emergency/Urgent Medical Care

I, _____, declare and state as follows:

1. I am competent to testify to the matters set forth herein, and testify based on my personal knowledge, education, information and belief.

2. I am a physician employed by the _____.
   My specialty is _____.

3. I received my medical degree from _____ in the year _____ and completed my residency in _____ at _____ in the year _____.

4. _____is a _____ year-old *(circle one)* male/female whom I examined on _____ for the purpose of _____
   _____.
   I have examined this person within one day or 24 hours of my certification herein.

5. _____'s present condition is as follows: _____
   _____
   _____
   _____
   _____.

6. It is my clinical opinion that because of his/her mental condition, _____ is unable to receive and evaluate information effectively, or his/her ability to communicate decisions is impaired to such an extent that he/she lacks the capacity to take actions to *(please check appropriate boxes)*:
   - [ ] obtain, administer and dispose of real and personal property, intangible property, benefits and income; AND/OR
   - [ ] provide health care, food, shelter, clothing, personal hygiene and other care without which serious physical injury or illness is more likely than not to occur; AND/OR
   - [ ] acquire and maintain those life skills that enable him/her to cope more effectively with the demands of his/her life; AND/OR
   - [ ] grant, refuse or withdraw consent to any medical treatment.

7. The recommended treatment or procedure is: _____
   _____
   _____
   _____.

8. This treatment or procedure is recommended and considered necessary because:
   _____
   _____
   _____
   _____.

9. In my professional opinion, this person requires immediate attention and treatment. The recommended treatment is (*please check appropriate box*): [ ] an emergency OR [ ] urgently necessary because: _____
_____
_____
_____
_____
_____.

10. I declare under penalty of perjury that the foregoing statements are true and correct to the best of my information, knowledge and belief.
Executed on _____, 20_____.

_____
Physician's Signature

_____
Physician's Name (*printed*)

_____
Street Address

_____
City, State and Zip Code

_____
Phone number/Pager number