

Emergency Medical Affidavit

I, _____, being first duly sworn, depose and say as follows:

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

2. I received my degree from _____ in _____. After completion of a residency in _____ at _____, I became employed at _____.

3. _____ is a _____ year-old _____ whom I examined on _____ for the purpose of _____.

I have examined this individual within one day or 24 hours of my certification herein.

4. _____'s present condition is as follows:

_____.

It is my opinion that because of his/her mental condition as evidenced above, _____ is unable to receive and evaluate information effectively, or her ability to communicate decisions is impaired to such an extent that he/she lacks the capacity to take actions to:

- 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 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.

5. The risks of the treatment/procedures are: _____

_____.

6. This procedure is necessary because: _____

_____.

7. In my professional opinion, this condition constitutes an emergency. This treatment is urgently necessary and needs to be completed as soon as possible because

Physician's Signature

Physician's Name (printed)

Street Address

City, State and Zip Code

Phone number/Pager number

Subscribed and sworn this _____ day of _____ 20__.

Notary Public

My commission expires: