CIRCUIT COURT FOR _____ (City/County) ☐, **MARYLAND**

Located at _____ (Court Address) **Case No.** _____

In the Matter of

_____ (Name of Disabled Person) _____ (Docket Reference)

MEDICAL CERTIFICATE - CESSATION OF DISABILITY
(Md. Rule 10-209(c)(5) and 10-710(e)(3))

NOTE TO PHYSICIAN: A petitioner will use this certificate to terminate guardianship of the patient named below because the patient no longer has a disability preventing them from making or communicating responsible decisions. The petitioner must submit the original certificate. Your answers must be specific and detailed and based on your personal examination of the patient. You must sign the certificate. You may complete the form yourself or have another person complete it under your supervision. The court may also require your testimony about this information. Attach additional sheets, if necessary.

Patient's Name: _____,

Patient's Address: _____

Patient's Date of Birth: _____ Patient's Sex: _____

I, _____ (Physician's name), employed by _____,

am a _____ (Year) graduate of _____ School of Medicine.

I am licensed to practice medicine in the United States in the following state(s): _____

My license number is: _____.

The following knowledge, training, board certification/eligibility, or experience qualifies me to examine the patient's functional capacity to make or communicate responsible decisions concerning their person (health care, food, clothing, shelter, etc.) or to manage their property or financial affairs:

I have known this patient for _____ (Length of time). My history of involvement with the patient is as follows:

Case No. _____

Examination and Diagnosis

I personally examined the above-named patient

☐ in person at **(select all that apply)**:

☐ a hospital/professional office/other facility, _____ (Facility name),
on _____ (Date(s)).

☐ at the patient's residence on _____ (Date(s)).

☐ other location **(describe)**: _____, located at
_____ (Address), on _____ (Date(s)).

☐ remotely, with audio and visual access to the patient, using _____ (Platform),
on _____ (Date(s)). I did not meet with the patient in person because:

The following individual(s) assisted the patient with the virtual examination:

Full Name	Title/Relationship	Phone Number	Email (if any)

The most recent examination lasted approximately _____ (Length of time). I performed or ordered the following tests and/or procedures.

I communicated with the patient in the following manner:

☐ English
☐ Other language or means **(explain)**: _____

Upon examination of the patient, I report the following findings:

Physical And Mental Conditions

Physical conditions

☐ None

☐ The patient has the following physical diagnoses:

Overall physical health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Explain:

Overall physical health will: ☐ Improve ☐ Be stable ☐ Decline ☐ Uncertain

Explain:

Mental conditions

☐ None

☐ The patient has the following mental (DSM-5) diagnoses **(attach additional sheets if needed)**:

Diagnostic Code	Description
.....	.....
.....	..... ☐ Mild ☐ Moderate ☐ Severe
.....	.....
.....	..... ☐ Mild ☐ Moderate ☐ Severe
.....	.....
.....	..... ☐ Mild ☐ Moderate ☐ Severe

The mental diagnosis/diagnoses affect functioning as follows:

Do temporary causes of mental impairment exist? ☐ Yes ☐ No ☐ Uncertain

If yes, have they been examined and treated? ☐ Yes ☐ No Explain:

Do reversible causes of mental impairment exist? ☐ Yes ☐ No ☐ Uncertain

If yes, have they been examined and treated? ☐ Yes ☐ No Explain:

List all medications:

Name	Purpose	Dosage/Schedule

Reversible or temporary somatic factors

Are there factors (hearing, vision or speech impairment, etc.) that may have limited the functional skills of the patient that could improve with time, treatment, disability accommodations, or assistive devices?

☐ Yes ☐ No ☐ Uncertain

Explain:

COGNITIVE FUNCTION

Alertness/level of consciousness

Overall impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Non-responsive

Describe below or ☐ in attachment

Memory, cognitive, and executive functioning

Overall impairment: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Non-responsive

Describe below or ☐ in attachment

Fluctuation

Symptoms vary in frequency, severity, or duration: ☐ Yes ☐ No ☐ Uncertain
Describe below or ☐ in attachment

EVERYDAY FUNCTIONING

The patient **is capable** of performing the Instrumental Activities of Daily Living (IADLs) **(select all that apply)**:

- ☐ Managing finances effectively **(select one)**: ☐without assistance ☐with assistance, specifically:
  _____
- ☐ Managing transportation needs **(select one)**: ☐without assistance ☐with assistance, specifically:
  _____
- ☐ Managing communication (e.g., telephone and mail) **(select one)**: ☐without assistance ☐with assistance, specifically:
  _____
- ☐ Managing medication **(select one)**: ☐without assistance ☐with assistance, specifically:
  _____
- ☐ Other executive functions **(describe)**:

The patient **is capable** of participating in the following civil or legal matters **(select all that apply)**:

- ☐ Signing documents **(select one)**: ☐without assistance ☐with assistance, specifically:
  _____
- ☐ Retaining legal counsel **(select one)**: ☐without assistance ☐with assistance, specifically:
  _____
- ☐ Participating in legal proceedings **(select one)**: ☐without assistance ☐with assistance, specifically:
  _____
- ☐ Other **(describe)**:

NEED FOR GUARDIANSHIP OF THE PERSON

(Select One)

- ☐ In my professional opinion, within a reasonable degree of medical certainty, the patient (**select one**) ☐ **does** ☐ **does not** have a disability that prevents them from making or communicating **any** responsible decisions concerning their **person**.

☐ In my professional opinion, within a reasonable degree of medical certainty, the patient has a disability that prevents them from making or communicating **some** responsible decisions concerning their **person**. Specifically, the patient is able to make decisions regarding:

but is unable to make decisions regarding:

NEED FOR GUARDIANSHIP OF THE PROPERTY

(Select one)

☐ In my professional opinion, within a reasonable degree of medical certainty, the patient (**select one**) ☐ **does** ☐ **does not** have a disability that prevents them from making or communicating **any** responsible decisions concerning their **property** and has a demonstrated inability to manage their **property** and affairs effectively because of physical or mental disability.

☐ In my professional opinion, within a reasonable degree of medical certainty, the patient has a disability that prevents them from making or communicating **some** responsible decisions concerning their **property**. Specifically, the patient is able to make decisions regarding:

but is unable to make decisions regarding:

I solemnly affirm under the penalties of perjury that the contents of this document are true to the best of my knowledge, information, and belief.

Date	Physician's Signature
Address	Printed Name
City, State, Zip	Telephone number
E-mail	Fax

Reset