

PHYSICIAN'S CERTIFICATE OF COMPETENCY

I, _____, M.D. /D.O, (please circle one) hereby certify as follows:

1. That I am a physician duly licensed to practice medicine in the State of Nevada, having specialized in the field of _____ for _____ years.
2. That on the _____ day of _____, 20____, I examined the following individual:

3. I am of the opinion that _____ is able to understand the nature, extent, or probable consequences of any proposed medical treatment, is able to make a rational evaluation of the burdens, risks, and benefits of any proposed medical treatment, and is able to communicate a decision regarding any proposed medical treatment.
4. I am also of the opinion that _____ is capable of comprehending the meaning of legal documents such as a Power of Attorney, Last Will and Testament, Living Will and Deed, and has the capacity to consent to the execution of these legal documents on his/her behalf.

I do hereby further certify, under the penalties of perjury of the State of Nevada, that all of the statements in the foregoing PHYSICIAN'S CERTIFICATE OF COMPETENCY are true and correct to the best of my knowledge, information and belief.

DATE: _____

PHYSICIAN PRINTED NAME

PHYSICIAN SIGNATURE

PHYSICIAN LICENSE NUMBER

PHYSICIAN PHONE NUMBER