

MEDICAL CERTIFICATE FOR GUARDIANSHIP

Report date: / /

Day Month Year

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| **TO BE COMPLETED BY THE PRIMARY PHYSICIAN OF THE WARD/PATIENT** | | |
| Patient’s full name: | | Social Security Number:  - - |
| Date of birth:  / / Day Month Year | Since when have you been treating the patient:  / / Day Month Year | Age: Height: Weight: Marital Status: Sex: |
| **INFORMATION ABOUT THE HEALTH CONDITION OF THE WARD/PATIENT** | | |
| Diagnosis:  Date of Diagnosis: / /  Day Month Year | | |
| Patient’s Medical History: | | |
| Current medical condition: ☐ Physical ☐ Mental ☐ Both **☐ Disabling ☐ Non-disabling**   * Mild ☐ Moderate ☐ Severe   Duration of condition: ☐ Permanent ☐ Temporary ☐ Progressive ☐ Static | | |
| Current Medications and/or Treatment: | | |

235 Avenida Arterial Hostos · Edificio Capital Center · Torre Norte, Hato Rey

PO Box 42003 San Juan, PR 00940-2203

Tel: (787) 777-1414 · www.retiro.pr.gov

A picture containing graphical user interface

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| Patient’s name: |
| 1. **Based on your professional opinion, does the patient have a mental disability that prevents him or her from managing his or her property or finances?**    * **Yes ☐ No** 2. **Based on your professional opinion, does the patient have a physical disability that prevents him or her from managing his or her property or finances?**    * **Yes ☐ No** 3. **Based on your professional opinion, does the patient require a guardian to manage his or her finances?**    * **Yes ☐ No** |
| **I certify that I have evaluated the patient and, based on my professional opinion, the patient meets one of the following circumstances:**   * His or her cognitive or emotional skills are permanently or significantly reduced or impaired, preventing him or her from appreciating the content and extent of ordinary and legal acts performed. * Has a mental disability that prevents him or her from managing his or her personal affairs or interests. * Has a mental disability that prevents him or her from performing daily activities and being independent. * Has a physical disability that prevents him or her from communicating effectively and requires assistance to be understood or actively or consciously participate in any legal act or consent to an obligation in writing. * Spends his or her estate extravagantly and wastefully, neglecting his or her duty to support his family and financial obligations. * Regularly uses intoxicating beverages, drugs, or substances controlled by law, and has developed such a degree of physiological or psychological dependence that produces a physical, mental or emotional state which prevents him or her from making correct decisions about his or her stability and personal safety; assets and financial solvency; legal obligations; and seeking rehabilitation. |
| **PATIENT’S SUPPORT RESOURCES** |
| **Does the patient have family support resources?** ☐Yes ☐No  **If patient has family support resources, check all that apply:**   * Spouse ☐ Parent ☐ Grandparent ☐ Sibling ☐ Child ☐ Nephew/Niece ☐ Uncle/Aunt * Other:   **Name of support resource:** |
| I understand that by completing and signing this form I am certifying that know the medical history of the patient. I recognize that the purpose of this form is to Certify the patient’s clinical condition for a determination of administrative guardianship before the Retirement Board of the Government of Puerto Rico. I understand that, by reason of the patient’s incapacity, guardianship grants a natural or legal person authority to represent and assist the patient evaluated by me in his or her claims before the Retirement System and to receive and manage the benefits granted by the Retirement Systems.  I affirm and declare **under penalty of perjury**, that the foregoing information is true and correct.  Physician’s Full Name Physician’s signature License Number  Specialty:  Address: Telephone number: Email Address: |