IN THE CIRCUIT COURT OF THE SIXTEENTH JUDICIAL CIRCUIT
KANE COUNTY, ILLINOIS

Case No. ____________________________

IN THE MATTER OF THE ESTATE OF (Alleged Disabled Person):

Name:____

Address:____

City, State, Zip: _________________________________

Date of Birth: ____________________________________

File Stamp

PHYSICIAN'S REPORT

____ , a physician licensed to practice medicine in all its branches in the State of Illinois, submits the following report on the above alleged disabled person.

1. Describe the nature and type of respondent's disability and an assessment of how the disability impacts on the ability of the respondent to make decisions or to function independently:

2. Describe the respondent's mental and physical condition and, where appropriate, describe educational condition, adaptive behavior, and social skills which have been performed within 3 months of the date of filing to this petition:

3. Your opinion as to whether guardianship is needed, the type and scope of the guardianship needed, and the reasons therefore:

4. Your recommendation as to the most suitable living arrangement and, where appropriate, treatment or habilitation plan for the respondent and the reasons therefore:

Case No.____________________________

Date:__________________ Physician's Name (please print):________________________________

Signature of Physician:________________________________

Address: ________________________________

City, State, Zip:________________________________

I, ____, hereby certify that:

1. I have personally examined., questioned, interviewed and/or evaluated the alleged disabled person named in the above Physician's affidavit.
2. As attested to below, the evaluation to which I have set me seal is in my opinion, true, correct and supported by fact.

Under penalties of perjury as provided by law pursuant to 735 ILCS 5/1-109, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters stated to be on information and belief and as to such matters the undersigned certifies that he/she verily believes the same to be true.

____
Signature

____
Print Name

This report must contain the signatures of all person(s) who performed the evaluations upon which the report is based on, of whom must be a licensed physician, and a statement of the certification, license or other credentials that qualify the evaluators who prepared this report.

1. Name:____
   Signature:____
   Address, City, State, Zip:________________________________
   Credentials:____

2. Name:____
   Signature:____
   Address, City, State, Zip:________________________________
   Credentials:____

3. Name:____
   Signature:____
   Address, City, State, Zip:________________________________
   Credentials:____