Cert No. _____

CERTIFICATION OF MENTAL CAPACITY BY AN ACCREDITED MEDICAL PRACTITIONER

I certify that I have examined the mental capacity of <Name of Patient> of <NRIC Number>, and assessed that he/she* lacks the mental capacity and:

☐ is incapable of managing himself/herself and his/her property & affairs

OR

☐ is unable to make the following specific decision(s)at the particular time:

<To be filled in the specific reason as per para 3.2 of Assessment Form>

I further certify that the Patient's inability to make the decision is due to:

☐ **short term incapacity (likely to exceed 3 months but less than 1 year)**
from DDMMYYYY to DDMMYYYY, when this Certificate expires.

OR

☐ **long term permanent incapacity (not likely to recover in the foreseeable future)**
This Certificate will expire in 6 months/1 year* of the date of this Certificate. A review must be made before the expiry of this Certificate.

Signature of Doctor _____ Date of issue _____
Name of Doctor: _____
Medical Registration No: _____

* Delete as appropriate

NOTE: This Certificate will be invalidated if the Patient regains capacity to make the specific decision before the expiry of this Certificate. The donee of a Lasting Power of Attorney must cease to act as donee if this occurs.