OPTIONAL EXAMINER'S CERTIFICATION

We, the undersigned, have made an examination of ___________, and do hereby certify that we have made a careful personal examination of the actual condition of the person and on such examination we find that __________________:

1. (Is) (Is not) in need of mental health treatment; and

2. (Does) (Does not) lack capacity to participate in decisions about (her) (his) mental health treatment.

The facts and circumstances on which we base our opinions are stated in the following report of symptoms and history of case, which is hereby made a part hereof.

According to the advance directive for mental health treatment, (name of patient) _____________________, wishes to receive mental health treatment in accordance with the preferences and instructions stated in the advance directive for mental health treatment.

We are duly licensed to practice in this state of New Mexico, are not related to _____________________ by blood or marriage and have no interest in her/his estate.

Witness our hands this _______ day of ____________, 20___
_________________________________ M.D., D.O., Ph.D., Other
_________________________________ M.D., D.O., Ph.D., Other
Subscribed and sworn to
before me this ________ day of _____________________, 20____
____
Notary Public

REPORT OF SYMPTOMS AND HISTORY OF CASE BY EXAMINERS

I. GENERAL

Complete name ___________________________________

Place of residence _________________________________

Sex ________ Ethnicity ____________________________

Age ________

Date of Birth _____________________________________

II. STATEMENT OF FACTS AND CIRCUMSTANCES

Our determination that the principal (is) (is not) in need for mental health treatment is based on the following:

____

____

Our determination that the principal does not have the capacity to participate in the principal's mental health treatment decisions is based on:

1. the principal's ability to understand and communicate the nature of the proposed health care or mental health treatment described as:

____

____

2. the principal's ability to understand and communicate the consequences of the proposed health care or mental health treatment described as:

____

____

3. the principal's ability to understand and communicate the significant benefits, risks and alternatives to the proposed health care or mental health treatment described as:

____

____

4. the principal's ability to understand and communicate a choice about the proposed health care or mental health treatment described as:

____

____

III. NAME AND RELATIONSHIPS OF FAMILY MEMBERS/OTHERS TO BE NOTIFIED

Other data ____

Dated at _________________, New Mexico, this ________ day
of ________________, 20____
____ M.D., D.O., Ph.D.,
____ Other Address

____ M.D., D.O., Ph.D.,
____ Other Address."