

**AFFIDAVIT OF MEDICAL DOCTOR AS TO INCAPACITY OF PERSON IN ORDER
FOR POWER OF ATTORNEY TO BECOME EFFECTIVE**

AFFIDAVIT

State of California

County of _____

_____ (*Name of Physician*), being first sworn,
deposes and says:

1. I am a practicing physician licensed by the state of California as a medical doctor and specialize in _____ (*e.g., family medicine*).

2. On _____ (*date*), I made a physical and mental examination of _____ (*name of person with incapacity*) at the request of _____ (*name of interested person, e.g., daughter*).

3. As a result of said examination, it is my opinion as a practicing physician licensed by the state of California as a medical doctor, that _____ (*name of person with incapacity*):

() is, by reason of advanced age, physical incapacity or mental weakness, incapable of managing his or her own estate.

() lacks the mental capacity to enter into a binding agreement or make decisions on his or her own behalf.

() does not have the ability to understand that a contract is being made and its general nature.

4. All the facts and opinions stated in this affidavit are true and correct to the best of undersigned's knowledge and belief.

Witness my signature this _____ day of _____, _____.

(*Printed Name & Signature of Physician*)

State of California
County of _____

On _____ before me, _____ (here
insert name and title of the officer), personally appeared _____

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are
subscribed to the within instrument and acknowledged to me that he/she/they executed the same
in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument
the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument. I
certify under PENALTY OF PERJURY under the laws of the State of California that the
foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)

SAMPLE