Physician or Healthcare Provider
Statement of Capacity

I, being the undersigned physician or healthcare provider, do hereby declare the following:

I have examined or treated:

_____ (patient's full name) in my capacity as a physician or healthcare provider. Because of this association, I have been acquainted with the patient for a period of:

_____ months and/or _____ years.

Upon review of the patient's medical records, I am of the opinion that:

_____ (patient's full name) is of sound mind and is competent to enter into contractual arrangements and make financial and legal decisions.

_____ _____ ___/___/___
(Signature) (Print Name) (Date)

Address*: _____

City: _____ State: _____ Zip:_____

Phone: _____

* May use official office stamp if available below:

UPON COMPLETION PLEASE FAX TO LIFETRUST, LLC
(214) 469-2037

(No Cover Page Needed)