BRITISH COLUMBIA

Adult Guardianship Act
FORM 1: REPORT OF ASSESSMENT OF INCAPABILITY

(Section 32 to 34 of the *Adult Guardianship Act*, Section 10 of the Statutory Property Guardianship Regulation)
(to be completed by a qualified health care provider)

I, _____ am a qualified health care provider
(name and profession)
under the *Adult Guardianship Act*.

I confirm that I have assessed _____, born _____
(name of adult) *(date of birth of adult - YYYY / MM / DD)*
to determine whether he/she is incapable of managing his/her financial affairs.

Purpose of Assessment
[mark the appropriate button]

◯ Assessment under section 32 of the *Adult Guardianship Act*

◯ Second assessment under section 33 of the *Adult Guardianship Act*

◯ Reassessment under section 34 of the *Adult Guardianship Act*, including for the purposes of section 35(3) of that Act

Determination of Qualified Health Care Provider
[mark the appropriate box]

My determination based on my assessment is that _____ is:
(name of adult)

◯ **Capable** of managing his/her financial affairs

◯ **Incapable** of managing his/her financial affairs

Details of the assessment are attached. (attach securely to this form all supporting documents)

Signature of Qualified Health Care Provider	Name of Qualified Health Care Provider	
	Address	
Date Signed (YYYY / MM / DD)	Telephone Number	Fax Number

Save Print Clear Form