

# FORM 1

**Adult Guardianship Act**  
**REPORT OF ASSESSMENT OF INCAPABILITY**  
*(Sections 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, \_\_\_\_\_ *[name and profession]*,  
am a qualified health care provider under the *Adult Guardianship Act*.

I confirm that I have assessed \_\_\_\_\_ *[name of adult]*,  
born \_\_\_\_\_ *[date of birth of adult]*, to determine whether he/she is  
incapable of managing his/her financial affairs.

### **Purpose of Assessment**

*[mark the appropriate box]*

- 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 \_\_\_\_\_ *[name  
of adult]* is

- Capable** of managing his/her financial affairs
- Incapable** of managing his/her financial affairs

\_\_\_\_\_ *[signature]*

\_\_\_\_\_ *[date]*

Details of the assessment are attached.  
*[attach securely to this form all supporting documentation]*

### Contact Information for Qualified Health Care Provider

\_\_\_\_\_ *[name of qualified health care provider]*

\_\_\_\_\_

\_\_\_\_\_ *[address]*

\_\_\_\_\_ *[telephone number]*

\_\_\_\_\_ *[fax number]*