

To be used with Section 18

**CHARACTER & FITNESS HEALTHCARE FORM**

**> TO BE COMPLETED BY A LICENSED HEALTHCARE PROFESSIONAL**  
**DESCRIPTION OF MENTAL HEALTH OR SUBSTANCE ABUSE CONDITION OR IMPAIRMENT**

Patient's Full Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN (Last 4) \_\_\_\_\_  
Dates of Treatment From \_\_\_\_\_ To Month/Year \_\_\_\_\_  
Month/Year \_\_\_\_\_  
Treating Professional \_\_\_\_\_ Title \_\_\_\_\_  
Treatment Facility \_\_\_\_\_ Phone \_\_\_\_\_  
Current Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Describe the condition/diagnosis and any treatment or monitoring program for which you are or have treated the above-named Applicant:

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Prognosis: Is it your opinion this condition will affect this person's fitness or ability to perform the duties of an attorney in a professional and competent manner?  
Yes or No If yes, please explain

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\_\_\_\_\_  
Licensed Healthcare Professional – Print Name

\_\_\_\_\_  
Licensed Healthcare Professional Signature

\_\_\_\_\_  
Date