CHARACTER & FITNESS HEALTHCARE FORM

➢TO BE COMPLETED BY A LICENSED HEALTHCARE PROFESSIONAL

Patient's full name _____ Dates of treatment from month/year _____

DOB _____ To month/year _____

SSN (Last 4) _____

Treating professional _____ Title _____

Treatment facility _____ Phone _____

Current street _____

Street 2 _____

City _____ State _____ ZIP _____

Describe the condition/diagnosis and any treatment or monitoring program for which you are or have treated the above-named Applicant in the past five (5) years:

Prognosis: Is it your opinion this condition will affect the Applicant's fitness or ability to perform the duties of an attorney in a competent, ethical and professional manner?

☐ Yes ☐ No If yes, please explain:

_____ _____

Licensed Healthcare Professional – Print Name Licensed Healthcare Professional Signature

_____

Date