SCHEDULE 1

Regulation 2

CERTIFICATE UNDER SECTIONS 15(3)(c) AND/OR 16(3)(c) OF THE ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000 TO BE INCORPORATED IN A DOCUMENT GRANTING A POWER OF ATTORNEY

1. This certificate is incorporated in the document subscribed by

Insert name of granter

2. On

Insert date subscribed

3. That confers a

Tick appropriate box – tick one box only

- ☐ • Continuing power of attorney (i.e. confers property or financial powers only)
- ☐ • Welfare power of attorney (i.e. confers welfare powers only)
- ☐ • Combined power of attorney (i.e. confers both property or financial and welfare powers)

4. Appointing as Attorney(s)

Insert name(s) of Attorney(s)

5. Declaration of Certifier

Note: any person signing this certificate should not be the person to whom this power of attorney has been granted.

I certify that

1. I interviewed the granter ***immediately*** before he/she subscribed this power of attorney;

2. I am satisfied that, at the time this power of attorney was granted, the granter understood its nature and extent; and

I have satisfied myself of this:
Please tick appropriate box. (Both may apply but one must apply)

☐ (a) because of my own knowledge of the granter;

and/or

☐ (b) because I have consulted the following person who has knowledge of the granter on the matter

Insert name, address and relationship with granter, of person consulted

3. I have no reason to believe the granter was acting under undue influence or that any other factor vitiates the granting of this power of attorney.

Signed: .....

Print name: .....

Profession: .....

Address: .....

.....

.....

Date: .....

SCHEDULE 1

Regulation 3

(As amended)
AWI[1]
Adults with Incapacity (Scotland) Act 2000
Section 57(3)(a) and 60(3)(a)

Report of incapacity to accompany

application for guardianship ⁎
application for renewal of guardianship ⁎
application for intervention order ⁎

Note: fill in Part A1 where the adult is examined in Scotland and Part A2 where the adult is examined outwith Scotland.

PART A1 DETAILS OF REPORT WRITER AND ADULT FOR EXAMINATIONS IN SCOTLAND

I [ ] (name)

being a medical practitioner with the following professional address:

[ ] (state full postal address for contact)

Telephone [ ] E-mail [ ]

[*complete the following box if applicable*(**1**)*; otherwise, delete*]

and being approved by the [ ] Health Board/ by the State Hospital's Board for Scotland (*please delete one*)

for the purposes of section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 as having special experience in the diagnosis and treatment of mental disorder,

hereby confirm that I examined and assessed the following adult ("the adult")

Name [ ]

Residing at [ ] (state full postal address)

⁎ delete the two which do not apply

(**1**) Where the incapacity is by reason of mental disorder, one of the medical practitioners must be approved for the purposes of section 22 of the 2003 Act as having special experience in the diagnosis and treatment of mental disorder (section 57(6B) of the Act).

Date of birth

On (give date of examination and assessment)

OR

PART A2 DETAILS OF REPORT WRITER AND ADULT FOR EXAMINATIONS OUTWITH SCOTLAND

I (name)

being a medical practitioner with the following professional address:

(state full postal address for contact)

Telephone E-mail

having the following qualification and special experience in relation to the treatment of mental disorder:

and having consulted the Mental Welfare Commission(**2**) about this report (*please tick box*)

hereby confirm that I examined and assessed the following adult ("the adult")

Name

Residing at (state full postal address)

Date of birth

On (give date of examination and assessment)

At (insert place and address of assessment)

(**2**) Postal address: The Mental Welfare Commission, Floor K, Argyle House, 3 Lady Lawson Street, Edinburgh, EH3 9SH. Telephone: 0131 222 6111. Website: www.mwcscot.org.uk

PART B PURPOSE OF EXAMINATION AND ASSESSMENT

The examination and assessment was in connection with a proposed application for (tick whichever applies)

A guardianship order*/renewal of guardianship order*/an intervention order

a) with power over personal welfare ☐

b) with power over property and/or financial affairs ☐

c) with power over personal welfare, property and/or financial affairs. ☐

Name of applicant or person requesting report

Name(s) of person or persons nominated in application (if known)

PART C FINDINGS OF EXAMINATION AND ASSESSMENT

On the basis of my examination and assessment I am of the opinion that the adult named in Part A has *(tick box for whichever of the following applies and add comments on nature*

a) Mental disorder**3** ☐

Nature

And /or

b) Inability to communicate because of physical disability ☐

Nature

* delete the two which do not apply

3 Mental disorder has the meaning given to it in section 328 of the Mental Health (Care and Treatment) (Scotland) Act 2003, namely that it means any mental illness; personality disorder or learning disability however caused or manifested, but an adult is not mentally disordered by reason only of sexual orientation; sexual deviancy; transsexualism; transvestism; dependence on, or use of, alcohol or drugs; behaviour that causes, or is likely to cause, harassment, alarm or distress to any other person; or acting as no prudent person would act.

I am of the opinion that the condition mentioned in Part C has impaired the capacity of the adult named in Part A to make decisions about or to act to safeguard or promote his/her interests in his/her property, financial affairs or personal welfare in relation to the matters covered in the proposed application. The reason for my opinion is given below.

Please indicate the findings of your examination and assessment, so far as they relate to the adult's capacity in relation to the matters which are the subject of the application.

Please indicate the likely duration of the incapacity

Please indicate the extent to which you have been able to communicate with the adult,

Please indicate the extent to which you have been able to consult the nearest relative, primary carer, named person and anyone else having an interest in, or knowledge of, the adult.

PART D DECLARATION OF INTEREST

Delete (a) or (b)

(a) I am not related to the adult

(b) I am related to the adult being his /her *(state relationship)*

AND

Delete (c) or (d)

(c) I have no pecuniary interest
*in the appointment of a guardian or guardians**
*in the renewal of guardianship**
*in the intervention order sought**

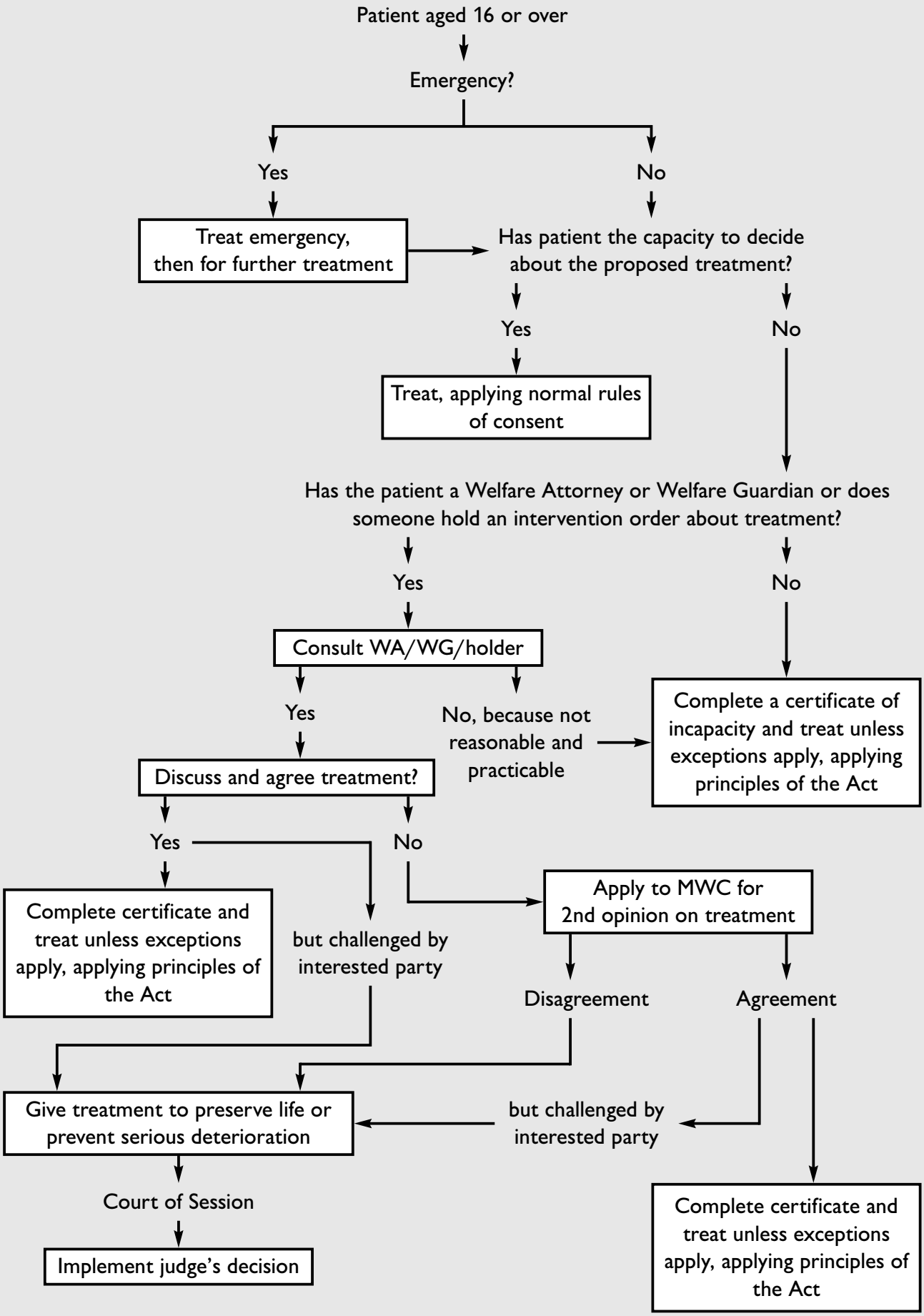
(d) I have a pecuniary interest
*in the appointment of a guardian or guardians**
*in the renewal of guardianship**
*in the intervention order sought******
The nature and extent of that interest is

Signed**4**

Date

***** delete the two which do not apply.
4 Please note that the application and accompanying reports will be served on interested parties.

ADULTS WITH INCAPACITY (SCOTLAND) ACT 2000
PART 5 – MEDICAL TREATMENT – FLOWCHART



Astron B24025 05/02

Certificate of Incapacity under Section 47 of the Adults with Incapacity (Scotland) Act 2000

I _____ (name)

of _____ (address)

*am the medical practitioner primarily responsible for the medical treatment of; or

*am a person who is *a dental practitioner/an ophthalmic optician/a registered nurse and who satisfies such requirements as are prescribed by the Adults with Incapacity (Requirements for Signing Medical Treatment Certificates) (Scotland) Regulations 2007 and who is primarily responsible for treatment of the kind in question of:

_____ (name)

of _____ (address) D D M M Y Y (date of birth)

for whom the *guardian/welfare attorney/person appointed by intervention order/nearest relative/carer

is _____

I have examined the patient named above on D D M M Y Y (date). I am of the opinion that *he/she is incapable within the meaning of the Adults with Incapacity (Scotland) Act 2000 ("the 2000 Act") in relation to a decision about the following medical treatment:

_____

because of (nature of incapacity) _____

_____

_____

This incapacity is likely to continue for _____ months.

*I therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist from:

D D M M Y Y (date of examination) until D D M M Y Y, being a period which does not exceed one year from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me; or

*I am of the opinion that (a) *he/she is suffering from *a severe or profound learning disability/dementia/a severe neurological disorder; and (b) *what he/she is suffering from is unlikely to improve within the meaning of the Adults with Incapacity (Conditions and Circumstances Applicable to Three Year Medical Certificates) (Scotland) Regulations 2007/ Y Y and therefore consider it appropriate for the authority conferred by section 47(2) of the 2000 Act to subsist until:

D D M M Y Y being a period which does not exceed three years from the *date of the examination on which this certificate is based/date of revocation of the certificate issued previously by me.

The authority conferred by section 47(2) of the 2000 Act shall subsist for the period specified above or until such earlier date as this certificate is revoked.

In assessing the capacity of the patient, I have observed the principles set out in section 1 of the 2000 Act.

Signed _____ Date D D M M Y Y

*delete as appropriate