

B. Dental

1. Date of examination(s)

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2. Name and address of examining dentist(s)/physician(s)

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| |
| (Dentist/Physician Name) _____ |
| _____ |
| _____ |
| _____ |

3. Place of examination(s)

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4. Report of examination(s) (Guardian may attach copy of additional examination reports)

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C. Mental health treatment (including hospitalizations)

1. Date of examination(s)

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2. Name and address of treating clinician(s)

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| _____ |
| _____ |
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3. Place of examination(s)

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4. Report of examination(s) (Guardian may attach copy of additional examination reports)

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D. Report of guardian on performance of duties

E. Report of the ward's residence, education, employment, and rehabilitation or habilitation

F. Report of guardian's efforts to seek least restrictive alternatives including

1. Restoration

2. Transfer

3. Limited

4. Alternatives

G. Other Reports

(Guardian's Signature)

(Agency)

(Street Address)

(City)

(State)

(Zip Code)

(Telephone Number)

I, _____ (Guardian), first being duly sworn, affirm that the
foregoing status report is complete and accurate to the extent that I can determine and am
informed as to the status of _____ (Ward)

(Guardian's Signature)

Sworn to and subscribed before me

This _____ day of _____

(Notary Public)

My commission expires: _____

submitted to: _____

Clerk

Other

Date: _____