

MAIL ALL FIVE COMPLETED FORMS TO:

**NYS Justice Center for the Protection  
of People with Special Needs  
SDMC  
161 Delaware Avenue  
Delmar, NY 12054**

**INSTRUCTIONS FOR SDMC FORM 310  
Certification on Capacity**

*If this is your first time preparing a case or you have questions, call 518-549-0328.*

**Verify the answer includes. . . .**

1. . . . the full name of the Attending Physician completing the examination/interview, the name of the patient and the physician's license number.
2. . . . the full mailing address and work and fax phone numbers of the Attending Physician completing the examination/interview.
3. . . . the Attending Physician's determination of the cause and nature of the patient's mental disability/incapacity and the expected duration of that incapacity.
4. . . . the signature of the Attending Physician and the date the affirmation is made by the Attending Physician.
5. . . . the full name of the Consulting Physician or Licensed Psychologist completing the examination/interview, their title and their license number.
6. . . . the full mailing address and work and fax phone numbers of the Consulting Physician or Licensed Psychologist completing the examination/interview.
7. . . . the date the patient was examined/interviewed, the patient's name and mental disability/diagnosis, including the cause and nature of the patient's incapacity.
8. . . . the Consulting Physician's or Licensed Psychologist's determination of the expected duration of that incapacity.
9. . . . the results of the most recent psychological tests and or the patient's IQ/mental age, if available. **NOTE:** The patient does not have to undergo testing in order to complete this form.
10. . . . a summary of the clinical evaluation and patient's reaction that validates the opinion that patient does not have the capacity to make this/these decision(s).
11. . . . the signature of the Consulting Physician or Licensed Psychologist completing the examination/interview and date.
12. . . . the name of the physician or licensed psychologist who meets the specialized criteria to certify a request to withhold or withdraw life sustaining treatment as required by Article 17-A, Section 1750-b of the Surrogate's Court Procedure Act. The physician or licensed psychologist making the certification checks at least one of the criteria, then signs and dates the form.