Declaration of Incapacity by Medical Practitioner

To whom it may concern:

Re: ___________________________________ (the Patient)

(print name of Patient)

I am a Medical Practitioner qualified to practice in ______________________ (name of jurisdiction). I hereby certify that I have examined the Patient, and I do hereby declare that they are mentally incapacitated to the point that they could not vote in the upcoming Tłegǫ́hłı̨ Got'ı̨nę Ratification Vote.

DATED at __________, _______, this _____day of _____________, 202_.

____

Medical Practitioner

____

Print Name

Address

____

____

This Declaration has been submitted by the undersigned parent/legal guardian (circle appropriate description) of the Patient.

____

Print Name of Parent/Guardian

____

Phone number or email address