# Testamentary Capacity Assessment

## To: The Executor of the Estate of ___________________________________

I, ______________________________________________________, a medical practitioner practising in _________________________________, (registration number ________________) certify that _____________________________________ was a patient of mine for ________years.

I have been asked by _______________________________ to make a retrospective assessment of the testamentary capacity of ___________________________________ at the time he/she made his/her last Will on ___________________________.

In my opinion, as at _________________, ______________________________________:

- Would/would not have understood what a Will is and what its consequences are.
- Would/would not have known the nature and extent of his/her assets and liabilities.
- Would/would not have known the names and relationships of his/her close relatives and would/would not have been able to assess their claims to his/her estate.
- Was/was not free from any disorder of the mind that might distort feelings or judgements relevant to making a Will

*Please delete above options as required.

In my opinion, ________________________________ had/did not have testamentary capacity to make his/her Will on ___________________________________.

My scope of practice includes the assessment of mental capacity.

Dated: ___________/__________________/______________

Signature: _________________________________________