

IN THE CIRCUIT COURT, SEVENTH  
JUDICIAL CIRCUIT, IN AND FOR  
FLAGLER COUNTY, FLORIDA

IN RE: GUARDIANSHIP OF:

PROBATE DIVISION

\_\_\_\_\_

CASE NUMBER: \_\_\_\_\_

DIVISION: 48

ANNUAL GUARDIANSHIP PLAN (GUARDIANSHIP REPORT) OF GUARDIAN OF THE  
PERSON (ADULT WARD)

\_\_\_\_\_, the guardian of the person of \_\_\_\_\_

(the Ward), submits the following plan as the Annual Guardianship Plan of this guardian:

The Annual Guardianship Plan for the period beginning \_\_\_\_/\_\_\_\_/\_\_\_\_, and  
ending \_\_\_\_/\_\_\_\_/\_\_\_\_ shall be as follows:

1. The Ward's address at the time of filing this plan is:

\_\_\_\_\_  
\_\_\_\_\_

2. During the prior twelve (12) months, the Ward resided at:

\_\_\_\_\_  
\_\_\_\_\_

3. The Current residential setting best suited for the current needs of the Ward is as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. The plan for the next twelve (12) months to ensure the Ward is in the best residential setting to meet the Ward's needs is as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Any professional medical treatment given to the Ward during the prior twelve (12) months was as follows:

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6. Attached is a report of a physician who examined the Ward no more than ninety (90) days before the date this plan is filed, including that physician's evaluation of the Ward's condition and a statement of the current level of capacity of the Ward.

7. The plan for provision of medical, mental health and rehabilitation services in the next twelve (12) months is as follows:

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8. The following information is submitted concerning the social condition of the Ward:

a. The social and personal services currently used by the Ward are as follows:

NAME AND ADDRESS	SERVICES RENDERED
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

b. The following is a statement of the social skills of the Ward, including how well the Ward communicated and maintains interpersonal relationships:

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c. The following is a description of the social needs of the Ward:

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9. During the prior twelve (12) month period, the following activities were efforts to enhance the capacity of the Ward:

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10. The following is a list of any preexisting orders not to resuscitate executed under s. 401.45(3) or preexisting advance directives, as defined in s. 765.101. (For every directive or order listed, include the date the order or directive was signed, and whether such order or directive has been suspended by the court):

ORDER OR DIRECTIVE	DATE EXECUTED
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

11. Give a description of the steps taken to identify and locate the preexisting order not to resuscitate, or advance directive:

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12. Is the Ward now capable of having some or all his/her rights restored? If so, identify the rights that should be restored:

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13. Do you plan to seek the restoration of any rights to the Ward?

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14. This plan HAS/ HAS NOT (*circle one*) been reviewed with the Ward.

Under penalties of perjury, I declare that I have read the foregoing, and the facts alleged are true, to the best of my knowledge and belief.

Signed on \_\_\_\_/\_\_\_\_/\_\_\_\_.

Signature: \_\_\_\_\_  
Guardian Advocate

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_\_\_

IN THE CIRCUIT COURT OF THE SEVENTH JUDICIAL CIRCUIT,  
IN AND FOR FLAGLER COUNTY, FLORIDA

Case Number: \_\_\_\_\_  
Division: 48

IN RE: THE GUARDIAN ADVOCACY OF:

\_\_\_\_\_

PHYSICIAN'S REPORT- ADULT WARD  
(Required by Florida Statutes, Section 744.3675)

1. Name of Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_
2. Name of the Ward: \_\_\_\_\_
3. Date of examination: \_\_\_\_\_
4. Purpose of examination: \_\_\_\_\_  
\_\_\_\_\_  
a. Regular Checkup: \_\_\_\_\_  
\_\_\_\_\_  
b. Treatment for: \_\_\_\_\_  
\_\_\_\_\_
5. Evaluation of Ward's condition: (specify mental and physical condition at time of examination):  
\_\_\_\_\_  
\_\_\_\_\_
6. Description of Ward's capacity to live independently: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Does Ward continue to need assistance of a guardian?  
(circle one)      YES      NO
8. Is the Ward capable of being restored to capacity at this time?  
(circle one)      YES      NO
9. Date of this report: \_\_\_\_\_
10. Signature of physician completing this report: \_\_\_\_\_