



**Medical Examination Report**  
*(must be completed by a licensed physician)*

Principal Diagnosis/Symptom (describe physical condition, disease, or syndrome and provide a detailed description of the person's physical incapacity):

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Medical/Treatment Care History During Incarceration:

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Prognosis/Activities of Daily Living (include the likelihood of the person's recovery from the physical condition, disease, or syndrome and the extent of any potential recovery):

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Placement Possibilities (aftercare plan, payment, etc.):

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Additional Comments:

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***I have determined that the above-named individual suffers from an incapacitating condition, disease, or syndrome.***

Examining Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_