

INTERDICTION WORKSHEET

Disabled Child / Adult:

Name: _____

Address: _____

Age: _____ Date of Birth: _____ Level of education: _____

Marital Status: Single Married Divorced Widow(er)

(If married, spouse's name): _____

Spouse's Address if different:

Age: _____ Date of Birth: _____ Level of education: _____

Employer's Name: _____

Employer's Address: _____

Job Title: _____ How long employed? _____

Does disabled adult have any children? Yes No

(If yes, name of children, age, date of birth, employer name and address, job title, and length of employment):

Name: _____

Age: _____ DOB: _____ Employed: Yes No

Employer's Name: _____

Employer's Address: _____

Job Title: _____ How long employed? _____

Name: _____

Age: _____ DOB: _____ Employed: Yes No

Employer's Name: _____

Employer's Address: _____

Job Title: _____ How long employed? _____

Name: _____

Age: _____ DOB: _____ Employed: Yes No

Employer's Name: _____

Employer's Address: _____

Job Title: _____ How long employed? _____

What is mental capacity of disabled child/adult? _____

What is the nature of the disability? _____

Does disabled child/adult have any physical problems? Yes No

(If so, please explain): _____

What are/were the circumstances surrounding the disability? _____

Has the disability been present since birth or was it caused by an accident?

Birth Accident

If caused by an accident, at what age and what type of accident?

Age: _____ Type of accident: _____

Mother's Name: _____ Living: Deceased:

Address: _____

Age: _____ Date of Birth: _____ Level of education: _____

Degree? Yes No

Name and address of employer: _____

Job Title: _____ How long employed: _____

Father's Name: _____ Living: Deceased:

Address: _____

Age: _____ Date of Birth: _____ Level of education: _____

Degree? Yes No

Name and address of employer: _____

Job Title: _____ How long employed? _____

Names and ages of disabled child/adult's siblings:

Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

Name of disabled child/adult's current treating physician:

Physician: _____ Phone No.: _____
Address: _____
Current diagnosis: _____

Appointed Curator:

Name: _____ Phone No.: _____
Address: _____
Age: _____ Education level: _____ Employer: _____
Email Address: _____

Appointed Under-Curator:

Name: _____ Phone No.: _____
Address: _____
Age: _____ Education level: _____ Employer: _____
Email Address: _____

Does disabled child/adult have an interest in any property?

(If so, please provide descriptions, locations, values): _____

