

BEHAVIORAL HEALTH ADMINISTRATION

Catonsville, MD 21228

PHYSICIAN’S, PSYCHOLOGIST’S, OR PSYCHIATRIC NURSE PRACTITIONER’S

 CERTIFICATE TO ACCOMPANY

APPLICATION FOR VOLUNTARY ADMISSION OF A DISABLED PERSON

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Physician, Psychologist, or Psychiatric Nurse Practitioner  Name of Facility or Office Address Telephone Number

certify that on \_\_\_\_/\_\_\_\_/20\_\_\_\_, I personally examined:

Name of Disabled Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_

 Last First MI

Address of Disabled Person:

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

 Street City State County Telephone Number

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

 Birth Date Age Sex Marital Status SS#

Hispanic or Latino Origin: ⬜ yes ⬜ no

Race (check all applicable racial categories):

 ⬜ American Indian or Alaska Native

 ⬜ Asian

 ⬜ Black or African American

 ⬜ Native Hawaiian or other Pacific Islander

 ⬜ White

Name of Guardian of the Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City, State, Zip Telephone Number

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THE DIAGNOSIS OF MENTAL DISORDER IS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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SYMPTOMS:

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CURRENT MEDICATIONS (type and dosage): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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EMERGENCY MEDICATIONS, IF ANY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I certify that the following criteria for voluntary admission have been met:

⬜ The Disabled Person has a mental disorder;

 ⬜ The mental disorder is susceptible to care or treatment;

 ⬜ The Disabled Person understands the nature of the request for admission;

 ⬜ The Disabled Person is able to give continuous assent to retention by the facility; and

 ⬜ The Disabled Person is able to ask for release.

* I certify that the Disabled Person has the capacity to execute an application for voluntary admission.
* I certify that the Disabled Person understands both the criteria for voluntary admission and the procedure for requesting discharge from the facility.
* The medical examination on which this certificate is made was not conducted more than 1 week before this certificate was signed.
* I do not have a financial interest, through ownership or compensation, in a proprietary facility to which admission is sought by the Disabled Person whose status is being certified.
* I am not related, by blood or marriage, to the Disabled Person or to the Guardian of the Person of the Disabled Person.
* If the Disabled Person is 65 years old or older and is seeking admission to a State facility, a geriatric evaluation team has determined that there is no available, less restrictive form of care or treatment that is adequate for the needs of the Disabled Person.

**Licensure:**

* I certify that I am licensed under the Health Occupations Article, Title 14, Annotated Code of Maryland, to practice medicine in the State of Maryland; OR
* I certify that I am licensed under the Health Occupations Article, Title 18, Annotated Code of Maryland, to practice psychology in the State of Maryland; OR
* I certify that I am licensed under the Health Occupations Article, Title 8, Annotated Code of Maryland, to practice nursing as a psychiatric nurse practitioner in the State of Maryland.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Physician, Psychologist or Psychiatric Nurse Practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_