**VERMONT DEPARTMENT OF MENTAL HEALTH**

**Commissioner Designation as a Physician/APRN Who Can Complete the Physician’s Certificate (First Certification)**

**Quiz**

Please answer the following questions after you have attended the QMHP classroom training or have completed the on-line training.

1. By completing the First Certification on an individual, you as the physician/APRN may be required to testify at a court hearing regarding your determination.

[ ]  True [ ]  False

1. Dangerousness to self means that the person has behaved in such a manner as to indicate that patient is unable, without supervision and the assistance of others, to satisfy the need for nourishment, personal or medical care, shelter, or self-protection and safety, so that it is probable that death, substantial physical bodily injury, serious mental deterioration or serious physical debilitation or disease will ensue unless adequate treatment is afforded

[ ]  True [ ]  False

1. As a physician/APRN, you can rely on the Qualified Mental Health Practitioner’s (QMHP) assessment and simply note that you concur with that assessment on the Physician’s Certificate form.

[ ]  True [ ]  False

1. The three elements of assessment to determine whether or not a person is in need of treatment are:

[ ]  Criminal behavior, substance intoxication and absence of less restrictive options

[ ]  Mental illness, developmental disability and dangerousness

[ ]  Mental illness, danger to self or others and absence of less restrictive alternatives

[ ]  Criminal behavior, danger to self or others and absence of less restrictive alternatives

1. An Application for Emergency Examination/Physician’s Certificate for involuntary admission to a hospital can be done even if a competent patient agrees to voluntary admission for the appropriate care.

[ ]  True [ ]  False

Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_