FORM NO. MH-9A
Revised 11/2015

TO COMMENCE PROCEEDINGS FOR THE
INVOLUNTARY TREATMENT OF AN INDIVIDUAL
NON EMERGENCY

To the Family Court comes _____
(please print full name of applicant)

of _____
(please print complete address of applicant)

Telephone Number _____

Relationship to or interest in proposed patient* _____

and makes application for the involuntary treatment of _____
(please print full name of proposed person in need of treatment)

of _____
(please print complete address of proposed person in need of treatment)

***NOTE:** Only the following persons may make application for an individual's involuntary treatment: a guardian, spouse, parent, adult child, close adult relative, a responsible adult friend, a person who has the individual in his or her charge or care (e.g. a superintendent of a correctional facility), a law enforcement officer, a licensed physician (**Caution:** same physician cannot be both applicant and certifying physician), a head of a hospital or his or her written designee, or a mental health professional (i.e., a physician, psychologist, social worker, nurse or other qualified person designated by the Commissioner of the Department of Mental Health).

REASON FOR APPLICATION: (State the facts which you have gathered either from your own personal observations or as reliably reported to you by another person which lead you to believe that the proposed patient is in need of involuntary treatment.) **BE SPECIFIC!**

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(CONTINUE ON REVERSE SIDE)

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(If additional space is required, please continue on a separate sheet of paper)

Signed under the penalties of perjury
pursuant to 18 V.S.A. § 7612(d)(2)

Date of Application

Signature of Applicant

I certify that no physician's certificate is attached due to the proposed patient's refusal to submit to an examination by a licensed physician. 18 V.S.A. § 7612(e)(2).

Signature of Applicant

NOTE TO APPLICANT: This application **MUST** accompany the proposed patient when he/she is to be taken to the hospital for an emergency examination. If the application is of a non-emergency nature, it shall be filed in the family court of the proposed patient's residence or, in the case of a non-resident, in any family court. If the application is of non-emergency nature and the proposed patient refused to submit to an examination by a licensed physician, the applicant should make a written statement to that effect in the space provided above and file the application with the family court.

FORM NO. MH-9C
Revised 11/2015

SECTION I
PHYSICIAN'S CERTIFICATE
NON-EMERGENCY

NOTE TO PHYSICIAN: Complete Sections I and II of the Physician's Certificate. If you feel that the patient represents an immediate danger of harm to himself or others if allowed to remain at liberty and therefore requires **IMMEDIATE** admission to a hospital for an emergency examination use the form entitled "Application for Emergency Examination" form MH-11.

I, the undersigned, hereby certify that I am a physician duly licensed to practice medicine in the State of Vermont and that I have made careful examination of the mental condition of

_____ of _____
(NAME) **(ADDRESS)**

in the County of _____, State of Vermont, and that I am of the opinion that **he/she** is a mentally ill person in need of treatment. The following information concerning the proposed patient and **his/her** family is submitted:

DATE OF BIRTH _____ **PLACE OF BIRTH** _____ **SEX:** _____

MARITAL STATUS---Single, Married, Domestic Partner, Divorced, Separated, Widowed, Unknown **(Circle One)**

NAME AND ADDRESS OF SPOUSE, If any _____

_____

Can the patient speak and understand English? _____ If not, what language? _____

NAME OF FATHER: _____ **ADDRESS:** _____
(If deceased, so state _____)

MAIDEN NAME OF MOTHER: _____ **ADDRESS:** _____
(If deceased, so state _____)

1. The following data (A-D) is not required but should be provided if appropriate and available.

   (A) Alien Registration No: _____ (B) V.A. Claim No: _____

   (C) Medicare No: _____ (D) Medicaid No: _____

2. How long have you known the patient? _____
3. Does the patient have any serious physical illness? _____ If so, describe _____

_____

_____

4. Has the patient been physically injured in the recent past? _____ If so, when, how and to what extent _____

_____

_____

(CONTINUED ON REVERSE SIDE)

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5. List current medications and any drug sensitivities:

6. Full name and address of guardian, if any, nearest relative or friend:

Relationship to/interest in patient:

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SECTION II
PHYSICIAN'S CERTIFICATE
NON-EMERGENCY

I have examined the patient _____ within five (5) days of the date the petition is filed. In
(NAME)
my opinion this patient is mentally ill and as a result of that mental illness, poses a danger of harm to him/herself or others. It is my further opinion that this patient needs treatment for his/her mental condition. I base this opinion on the following facts (please print or type). I understand that these statements are made under penalty of perjury pursuant to 18 V.S.A. § 7612(e)(1).

7. Facts observed by yourself (How did the patient look? What did the patient say? What did he do?) _____

8. Facts reliably reported to you and sources of these facts _____

(CONTINUED ON REVERSE SIDE)

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9. Pursuant to Vermont Statute, 18 V.S.A. § 7612(f), it is the obligation of the certifying physician to consider available alternative forms of care and treatment for the person's needs, without requiring hospitalization. Please list all steps taken in exploring alternative forms for care and treatment. (Note: Discussions of the alternatives available to the patient with a representative of an authorized screening agency designated by the Commissioner of Mental Health will assist the physician in complying with this requirement. These screening agents can be contacted on a 24-hour-a-day basis. For a current listing of the designated screening agents, call the Admissions Office at the Vermont Psychiatric Care Hospital, telephone number 802-828-2799)

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Signed under the penalties of perjury
pursuant to 18 V.S.A. § 7612(e)(1)

_____ _____
Date of Examination Signature of Physician

_____ _____
Time of Examination Please Print or Type Physician's Name

_____
Physician's Address

_____
Physician's Telephone Number

PHYSICIAN'S NOTE: The Application Form, Sections I and II of the Physician's Certificate are sent directly to the local family court.

I hereby waive any right I have to receive a copy of the notice of hearing from the Court pursuant to 18 V.S.A. § 7613. I understand that despite this waiver I may be called to testify at a hearing involving the above named proposed patient.

_____
Signature