Revised 10/2023

PHYSICIAN'S CERTIFICATE
EMERGENCY EXAM

NOTE TO PHYSICIAN:

To complete this form, you must be a licensed physician or an Advanced Practice Registered Nurse (APRN). While the Department of Mental Health requests all physicians and APRNs be designated by the Commissioner of Mental Health to complete Physician's Certificates, such designation is not required by law, and you may therefore complete the form without designation. If you are not currently designated, please go to **mentalhealth.vermont.gov/providers/physician-emergency-exam-certification** for information about becoming designated by the Commissioner of Mental Health.

Complete Sections I and II.

SECTION I

I, the undersigned, hereby certify that I am a licensed physician or APRN. I further state that I am licensed in the State of Vermont, and 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 this person is a person in need of treatment. The following information concerning the proposed patient is submitted:

DATE OF BIRTH_____**GENDER IDENTITY**_____

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

Parent/Legal Guardian (if applicable)_____

_____
(Name and address of Parent/Legal Guardian)

1. How long have you known the patient?_____

2. Has the patient had any recent illness or injury?_____

3. Is the patient currently medically cleared for inpatient psychiatric placement?_____

SECTION II

In my opinion this proposed patient_____ is
(NAME)
mentally ill and poses a danger of harm to self or others, and should be held for admission at a hospital for an emergency examination (second certification). I believe the proposed patient meets all three of the above criteria and base this opinion on the facts outlined below. (**NOTE:** For each of these three criteria, it is required that the physician identify separately facts they observed and those reliably reported to them by others. In each instance, the source of the information must be identified.)

Primary Encounter Diagnosis_____

4. What facts have you observed and/or were reliably reported to you (identify by whom) that lead you to believe that the proposed patient has a mental illness? What did the proposed patient say? What did the proposed patient do?

5. What facts have you observed and/or were reliably reported to you (identify by whom) that lead you to believe that the proposed patient poses a danger of harm to self or others *as a result of the mental illness*? What did the proposed patient say or do? To whom, specifically, is the proposed patient a danger and in what way?

6. Is there a less restrictive form of care than involuntary hospitalization that can meet the proposed patient's needs, such as voluntary admission, crisis bed referral, outpatient safety plan, etc.? If not, why not?

7. If applicable, what medication(s) were administered prior to this evaluation?

Time administered: _____ A.M. _____ P.M.

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

_____ Date of Certification

_____ Signature of Physician/APRN

_____ Time of Certification

_____ Print Physician/APRN's Name

_____ Hospital

_____ Physician/APRN's Telephone Number

NOTE: The Application for Emergency Exam and Sections I and II of the Physician's Certificate must accompany the proposed patient.

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**

Please fax a copy of this form to:
VPCH Admissions Office: Fax #: 802-828-2749
Phone #: 802-828-2799