

<b>STATE OF MICHIGAN PROBATE COURT COUNTY CIRCUIT COURT - FAMILY DIVISION</b>	<b>CLINICAL CERTIFICATE</b>	<b>FILE NO.</b>
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In the matter of \_\_\_\_\_

1. TO THE EXAMINER: The following is a statement that must be read to the individual before proceeding with any questions.

I am authorized by law to examine you for the purpose of advising the court if you have a mental condition which needs treatment and whether such treatment should take place in a hospital or in some other place. I am also here to determine if you should be hospitalized or remain hospitalized before a court hearing is held. I may be required to tell the court what I observe and what you tell me.

I certify that on this date I read the above statement to the individual before asking any questions or conducting any examination.

2. I further certify that I, \_\_\_\_\_, personally examined \_\_\_\_\_  
Name of examiner (type or print) Patient

at \_\_\_\_\_  
Name of place where examined and its address

on \_\_\_\_\_ starting at \_\_\_\_\_ and continuing for \_\_\_\_\_ minutes.  
Date Time

**INSTRUCTIONS:** Describe in detail the specific actions, statements, demeanor, and appearance of the individual, together with other information which underlie your conclusion. **Indicate the source of any information not personally known or observed.** If this certificate is to accompany a petition for discharge, state why the individual continues to be or is no longer a person requiring treatment or in need of hospitalization.

3. My determination is that the person is  
 mentally ill (has a substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life).  
 not mentally ill.

4. (if applicable) The person has  
 convulsive disorder.       alcoholism.       other drug dependence.  
 mental processes weakened by reason of advanced years.  
 other (specify): \_\_\_\_\_  
 been hospitalized involuntarily two or more times within the two-year period immediately preceding the filing of the petition and has rejected aftercare programs and treatment.

5. My diagnosis is: \_\_\_\_\_

6. Facts serving as the basis for my determination are: \_\_\_\_\_

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

(PLEASE SEE OTHER SIDE)

Do not write below this line - For court use only

6. (continued)

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7. Explain in the space below the facts which lead you to believe that future conduct may result in (check applicable box)

a. likelihood of injury to self. Facts:

Therefore, I believe that the examined person, as a result of mental illness, can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure self.

b. likelihood of injury to others. Facts:

Therefore, I believe that the examined person, as a result of mental illness, can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure others.

c. inability to attend to basic physical needs. Facts:

Therefore, I believe that the examined person, as a result of mental illness, is unable to attend to those basic physical needs (such as food, clothing or shelter) that must be attended to in order to avoid serious harm in the near future.

d. inability to understand need for treatment. Facts:

Therefore, I believe that the examined person, as a result of mental illness, is unable to understand the need for treatment, and continued behavior can reasonably be expected to result in significant physical harm to self or others.

8. I conclude the individual  is  is not a person requiring treatment.

9. (optional) I recommend  hospitalization  alternative treatment

as follows:

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I certify that I am a person authorized by law to certify as to the individual's mental condition. I am not related by blood or marriage either to the person about whom this certificate is concerned or to any person who has filed, or whom I know to be planning to file, a petition in this proceeding. I declare under the penalties of perjury that this certificate has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time of signing

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title (physician, psychiatrist, etc.)

\_\_\_\_\_  
Print or type name and business telephone no.