Form OMH 475A (9/00)

State of New York
OFFICE OF MENTAL HEALTH

# CERTIFICATE OF EXAMINATION BY DIRECTOR OF COMMUNITY SERVICES OR DESIGNEE

Person's Name (Last, First, M.I.) "C" No.

Sex.....Date of Birth.....

Address.....

I,_____, hereby certify that:

a. On the _____ day of _____, 20____, I personally examined _____, who was located at _____, and in my opinion this person has a mental illness for which immediate inpatient care and treatment in a hospital is appropriate.

b. It is my opinion that this person's mental illness is likely to result in serious harm to himself or herself or others. By "likely to result in serious harm," I mean:

(Check appropriate statements)

☐ a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself *("other conduct" shall include the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, provided that such refusal or inability is likely to result in serious harm if there is not immediate hospitalization);*

and/or

☐ a substantial risk of physical harm to other persons, as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

c. The behavior or specific act(s) of this person on which I base my opinion is (are) described in Part A of Form 475, "Application for Involuntary Admission on Certificate of a Director of Community Services or Designee".

d. (Check appropriate statement below and complete)

☐ I am a physician licensed to practice medicine in New York State and am the Director of Community Services for the mentally disabled for (City) (County) of_____.

or

☐ I am a physician licensed to practice medicine in New York State and have been designated by the Director of Community Services for the mentally disabled for (City) (County) of _____ _____ to conduct examinations on his or her behalf.

e. I certify that this person's hospital admission is medically necessary.

_____ Signature of Director of Community Services or Designee

_____ title

_____ Date

_____ Address

_____ Telephone Number