

CERTIFICATE OF EXAMINATION

IN ACCORDANCE WITH
SECTION 5122.11 ORC

Person's Name	Age	Sex	Race	Date of Birth	Place of Birth
Person's Address (street, city, state, zip code)					County

The undersigned certifies that he/she/they is/are a psychiatrist or a licensed clinical psychologist and a licensed physician (underline as appropriate) of the State of Ohio, and that the following are facts relating to the examination of the above named person.

I further certify that I have with care and diligence personally observed and examined the named person on the _____ day of _____ in the year _____ AD.

That said person was examined at (state place) _____ and as a result of such examination, I believe said person _____ (enter IS or IS NOT as applicable) mentally ill and subject to hospitalization by court order.

REMARKS: Please report your findings which support your recommendations for admission. Please indicate any physical or mental condition demanding the immediate attention of the admitting hospital (i.e., withdrawal symptoms due to addiction, need for insulin, recent severe head injury, tuberculosis, or other information examining physician considers important). Use reverse side if necessary.

Name and Title	MD
Address	
License No.	

Name and Title	
Address	
License No.	

Signed in the presence of _____ this _____ day of _____ in the year _____ AD.

The undersigned certifies, under oath, that the person has refused to submit to an examination by a psychiatrist, or by a licensed clinical psychologist and licensed physician.

Name	
Address	
License No.	

Signed in the presence of _____ this _____ day of _____ in the year _____ AD.