AOC-720B Doc. Code: ECIA Rev. 1-26 Page 1 of 2 Commonwealth of Kentucky Court of Justice *www.kycourts.gov* KRS 202B.100; 202B.120; 202B.130	**EXAMINATION CERTIFICATION FOR INVOLUNTARY ADMISSION**	Case No. _____ Court _____ County _____ Division _____

IN THE INTEREST OF:)
_____)
RESPONDENT)

Comes Affiant, _____, and states as follows:

1. I am (*check one*) ❑ employed in the community OR ❑ employed by a state operated ICF/ID facility as a: (*check one*)

❑ Qualified intellectual disabilities professional, who is: (*check one*)

❑ A physician licensed under the laws of Kentucky to practice medicine or osteopathy, or a medical officer of the government of the United States while engaged in the performance of official duties.

❑ A psychologist with the health service provider designation, a psychological practitioner, a certified psychologist, or a psychological associate licensed under the provisions of KRS Chapter 319.

❑ A licensed registered nurse with a master's degree in psychiatric nursing from an accredited institution and two years of clinical experience of which one year is with individuals with an intellectual disability; or a licensed registered nurse, with a bachelor's degree in nursing from an accredited institution, who has three years of inpatient or outpatient clinical experience of which one year is in the field of individuals with an intellectual disability and is currently employed by a ICF/ID licensed by the cabinet, a hospital, a regional community program for mental health or individuals with an intellectual disability, or a private agency or company engaged in the provision of services to individuals with an intellectual disability.

❑ A licensed clinical social worker licensed under the provisions of KRS 335.100, or a certified social worker licensed under the provisions of KRS 335.080 with two years of inpatient or outpatient clinical experience in social work of which one year shall be in the field of individuals with an intellectual disability and is currently employed by an ICF/ID licensed by the cabinet, a hospital, a regional community program for mental health or individuals with an intellectual disability, or a private agency or company engaged in the provision of services to individuals with an intellectual disability.

❑ A marriage and family therapist licensed under the provisions of KRS 335.300 to 335.399 with three years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community program for mental health or individuals with an intellectual disability.

❑ A professional counselor credentialed under the provisions of KRS 335.500 to 335.599 with three years of inpatient or outpatient clinical experience in psychiatric mental health practice and currently employed by a hospital or forensic facility licensed by the Commonwealth, a psychiatric unit of a general hospital, a private agency or company engaged in providing mental health services, or a regional community program for mental health or individuals with an intellectual disability.

OR

❑ Licensed psychiatrist, psychologist, or physician with special training and experience in serving individuals with an intellectual disability.

2. I examined Respondent, _____, on _____, and in my opinion:

A. Respondent (*check one*) ❑ is intellectually disabled. ❑ is not intellectually disabled. The facts that support this belief are:

_____

_____

_____

B. Respondent (*check one*) ❑ does ❑ does not present a danger or threat of danger to self, family, or others (substantial physical harm or threat of substantial physical harm, including actions which deprive self, family, or others of the basic means of survival including provision for reasonable shelter, food, or clothing). The facts that support this belief are:

_____

_____

_____

C. Respondent (*check one*) ❑ can ❑ cannot reasonably benefit from treatment available in an ICF/ID. The facts that support this belief are:

_____

_____

_____

D. Placement in an ICF/ID (*check one*) ❑ is ❑ is not the least restrictive alternative mode of treatment presently available (treatment given in the least confining setting which will provide an individual with an intellectual disability appropriate treatment or care consistent with accepted professional practice, which may include an institutional placement). The facts that support this belief are:

_____

_____

_____

3. My diagnostic impression is as follows:

a. _____

b. _____

_____ _____

Date Signature/Title

* * * * * * * * * *

Subscribed and sworn to before me by _____ on _____ in the county
(name) *(month/day/year)*

of _____, _____.
(county) *(state)*

_____
Name/Title

For Notaries: My commission expires: _____. My notary ID number is : _____.

Print Form **Reset Form**