



**EXAMINATION CERTIFICATION FOR
INVOLUNTARY HOSPITALIZATION**

Case No. _____
Court _____
County _____
Division _____

IN THE INTEREST OF: _____)

RESPONDENT _____)

Comes Affiant, _____, and states as follows:

1. I am a "Qualified Mental Health 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 psychiatrist 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 practice of official duties, who is certified or eligible to apply for certification by the American Board of Psychiatry and Neurology, Inc.
- ☐ 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 with individuals with a mental illness; or a licensed registered nurse, with a bachelor's degree in nursing from an accredited institution, who is certified as a psychiatric and mental health nurse by the American Nurses Association and who has three years of inpatient or outpatient clinical experience in psychiatric nursing and is currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in provision of mental health services or a regional community program for mental health and individuals with an intellectual disability.
- ☐ A licensed clinical social worker licensed under provisions of KRS 335.100, or a certified social worker licensed under the provisions of KRS 335.080 with three years of inpatient or outpatient clinical experience in psychiatric social work and currently employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community program for mental health and 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 and individuals with an intellectual disability.
- ☐ A professional counselor credentialed under the provisions of KRS Chapter 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 and individuals with an intellectual disability.
- ☐ A physician assistant licensed under KRS 311.840 to 311.862, who meets one of the following requirements:
1. Provides documentation that he or she has completed a psychiatric residency program for physician assistants;
 2. Has completed at least 1,000 hours of clinical experience under a supervising physician, as defined by KRS 311.840, who is a psychiatrist and is certified or eligible for certification by the American Board of Psychiatry and Neurology, Inc.;
 3. Holds a master's degree from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant or its predecessor or successor agencies, is practicing under a supervising physician as defined by KRS 311.840, and:
 - a. Has two years of clinical experience in the assessment, evaluation, and treatment of mental disorders; or
 - b. Has been employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community program for mental health and individuals with an intellectual disability for at least two years; or
 4. Holds a bachelor's degree, possesses a current physician assistant certificate issued by the board prior to July 15, 2002, is practicing under a supervising physician as defined by KRS 311.840, and:
 - a. Has three years of clinical experience in the assessment, evaluation, and treatment of mental disorders; or
 - b. Has been employed by a hospital or forensic psychiatric facility licensed by the Commonwealth or a psychiatric unit of a general hospital or a private agency or company engaged in the provision of mental health services or a regional community program for mental health and individuals with an intellectual disability for at least three years.

2. Prior to completion of the examination, I made a good-faith attempt to contact Petitioner to obtain any additional relevant information necessary to the petition.

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

A. Respondent (*check one*) ☐ is ☐ is not an individual with a mental illness. 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 as a result of the mental illness. The facts that support this belief are:

C. Respondent (*check one*) ☐ can ☐ cannot reasonably benefit from treatment. The facts that support this belief are:

D. Hospitalization (*check one*) ☐ is ☐ is not the least restrictive alternative mode of treatment presently available (treatment which will give an individual with a mental illness a realistic opportunity to improve the individual's level of functioning, consistent with accepted professional practice in the least confining setting available). The facts that support this belief are:

4. 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 : _____.

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