PHYSICIAN’S OR PSYCHOLOGIST’S CERTIFICATE TO ACCOMPANY
APPLICATION FOR INVOLUNTARY ADMISSION

Involuntary admissions of individuals to facilities for the care or treatment of mental disorders are governed by Health General Article, §§10-613 – 10-617, Annotated Code of Maryland and COMAR 10.21.01.

An application for involuntary admission of an individual may be made by any person who has a legitimate interest in the welfare of the individual. The application must be on the required form (DHMH #34), be dated and signed by the applicant, state the applicant’s relationship to the individual for whom involuntary admission is sought, and be accompanied by the certificates of two physicians or one physician and one psychologist.

A certificate for involuntary admission shall be on this form; be based on the personal examination of the physician or psychologist who signs the certificate; and include: (1) A diagnosis of the individual’s mental disorder, (2) An opinion that the individual needs inpatient care or treatment, and (3) An opinion that hospitalization is needed for the protection of the individual or another. A certificate may not be used for admission if the examination was done more than 1 week before the certificate is signed or more than 30 days before the facility receives the application for admission.

A certificate shall have attached to it any available medical reports or records that support the individual’s need for involuntary care or treatment in a facility, for the protection of the individual or others. If these reports or records are not readily available or do not exist, then one of the certifying physicians or psychologist shall submit a detailed note summarizing the medical history of the individual; stating the individual’s current symptoms and diagnosis, and giving an explanation of why, in the certifying physician’s or psychologist’s professional judgment, the individual meets the requirements for involuntary care of treatment. (Health-General Article, §10-616 and COMAR 10.21.01).

If the individual who has been certified cannot be admitted to a private facility, the individual may be admitted to the State facility that is designated to receive individuals, based on bed availability as determined by The Centralized Admissions Referral Center (CARC) for the Mental Hygiene Administration. For bed availability, please contact CARC at 1-866-MD ADMIT (1-866-632-3648).

The services and programs of the Department of Health and Mental Hygiene are provided on a non-discriminatory basis and in compliance with Title VI of the Civil Rights Act of 1964. Any complaints regarding alleged discrimination may be filed in writing with the Director, Mental Hygiene Administration, Spring Grove Hospital Center, 55 Wade Avenue, Dix Building, Catonsville, MD 21228, and the Office of Civil Rights, U.S. Department of Health and Human Services, 150 S. Independence Mall West, Suite 372, Philadelphia, PA 19106-3499.

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# CERTIFICATION BY PHYSICIAN OR PSYCHOLOGIST

I, ______________________, of ________________________________
Printed Name of Physician or Psychologist            Name of Facility or Office Address            Telephone Number

certify that on ______________________________, which is no more than 1 week prior to this date, I personally
Date of Examination
examined

Name of Individual:  LAST      FIRST      MIDDLE INITIAL
Address of Individual:  _________________________________________________________________________________
Street   City   State   County   Telephone Number

Date of Birth  Age  Race  Sex  Marital Status  Social Security Number

Next of Kin:  ___________________________________________________________________________________________
Name       Relationship to Individual
Address          Telephone Number

THE DIAGNOSIS OF MENTAL DISORDER IS:  ________________________________________________________________________________
SYMPTOMS:  _______________________________________________________________________________________________________________
CURRENT MEDICATIONS (type and dosage):  ________________________________________________________________________________
____________________________________________________________________________________________________________________________
EMERGENCY MEDICATIONS:
________________________________________________________________________________________________

I find that:
(1) The individual has a mental disorder;
(2) The individual needs inpatient care or treatment;
(3) The individual presents a danger to the life or safety of the individual or of others;
(4) The individual is unable or unwilling to be admitted voluntarily;
(5) There is no available, less restrictive form of intervention that is consistent with the welfare and
safety of the individual; and
(6) If the individual is 65 years old or older and is being referred for admission to a State facility, geriatric
evaluation team has determined evaluation team has determined that there is no available, less
restrictive form of care or treatment that is adequate for the needs of the individual.

☐ I am licensed under the Health Occupations Article, Title 14, Annotated Code of Maryland to practice
medicine in the State of Maryland; or

☐ I am licensed under the Health Occupations Article, Title 18, Annotated Code of Maryland, to practice
psychology in the State of Maryland, and am listed in the National Register of Health Service Providers in
Psychology.

I do not have a financial interest, through ownership or compensation, in a proprietary facility to which admission is
sought for the individual whose status is being certified.

I am not related, by blood or marriage, to the individual or to the applicant for the admission of the individual.

Date    Time                                  Signature of Physician or Psychologist

DHMH 2 (Rev. 2/23/06)
I, the undersigned □ physician □ psychologist have, on ______________ , examined ______________________ , and find that:

1. This individual suffers from the following mental disorder with the most current DSM diagnosis of:
   _______________________________ (Axis I non-substance abuse, as primary focus of treatment.)

2. The patient is in need of institutional inpatient care or treatment because ________________________________________________
   ______________________________________________________________________________________________________
   ______________________________________________________________________________________________________
   ______________________________________________________________________________________________________

3. The patient presents a danger to his/her own life or safety or the life or safety of others because _________________
   ______________________________________________________________________________________________________
   ______________________________________________________________________________________________________
   ______________________________________________________________________________________________________

4. The patient is □ unable or □ unwilling to be voluntarily admitted as evidenced by _________________________
   ______________________________________________________________________________________________________

5. There is no less restrictive alternative than inpatient psychiatric care available for the patient which is
   consistent with welfare and safety, in that ___________________________________________________________________
   ______________________________________________________________________________________________________

6. STATE HOSPITALS ONLY: For patients 65 years of age or older, the patient has been evaluated by the Adult
   Evaluation Referral Service, and no less restrictive form of intervention has been determined by that team to be
   appropriate for the patient;
   AERS evaluation was completed by ______________________ on ____________________.
   Name of AERS team member               Date

Certifying Physician's/Psychologist's Signature ______________________ Printed/Typed Name ______________________