Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

SUPPLEMENT TO SUPPORT IMMEDIATE HOSPITALIZATION

(To be used in addition to "Examination and Recommendation for Involuntary Commitment, Form 572-01)

CERTIFICATE

The Respondent,	
requires immediate hospital	lization to prevent harm to self or others because:
ertify that based upon my examination of the l the Respondent is (check all that apply	
☐ Mentally ill and dangerous to	self
☐ Mentally ill and dangerous to	
☐ In addition to being mentally	III, is also mentally retarded
Signature o	of Physician or Eligible Psychologist
Address:	
City State Zip:	
Telephone:	
Date/Time:	
Name of 24-hour facility:	
Address of 24-hour facility:	
	NORTH CAROLINA
	County
CC: 24-hour facility	Sworn to and subscribed before me this day of, 20
Clerk of Court in county of 24-hour facility	•
Note: If it cannot be reasonably anticipated that the clerk will receive the copy within 24 hours	(seal)
(excluding Saturday, Sunday and holidays) of the time that it was signed, the physician or eligible	
psychologist shall also communicate the findings to the clerk by telephone.	Notary Public
to the distribution	My commission expires:
	Pursuant to G.S. 122C-262 (d), this certificate <i>shall serve as</i> the Custody Order and the law enforcement officer or other person <i>shall</i> provide transportation to a 24-hr. facility in accordance with G.S. 122C-251.

TO LAW ENFORCEMENT: See back side for Return of Service

SUPPLEMENT TO EXAMINATION AND RECOMMENDATION FOR INVOLUNTARY COMMITMENT

RE	TURN OF SERVICE			
□ Respondent WAS NOT taken into custody for the following reason:				
☐ I certify that this Order was received and served as follows:				
Date Respondent Taken into Custody	Time		☐ AM □ PM	
Name of 24-Hour Facility	Date Delivered	Time Delivered AM		
Name of Transporting Agency	Signature of Law En	forcement Official		