

County _____

Client Record # _____

File # _____

SUPPLEMENT TO SUPPORT IMMEDIATE HOSPITALIZATION

CERTIFICATE

To be used in addition to *First Examination for Involuntary Commitment*, Form [5-72-19](#)

The Respondent, _____ requires immediate hospitalization to prevent harm to self or others because:

I certify based upon my examination of the Respondent, which is attached hereto, the Respondent is (check all that apply)

- Mentally ill and dangerous to self
- Mentally ill and dangerous to others
- In addition to being mentally ill, has an intellectual disability

Signature of Commitment Examiner

Print Name of Commitment Examiner, Date and Time

Credentials (check one): MD/DO Eligible Psychologist PA NP (Master's-level or Higher) LCSW LCMHC LMFT
 LCAS (Substance Abuse Evaluation Only)

Name of Current Facility

Name of 24-Hour Facility

Address, City, State

Address, City, State of 24-Hour Facility

Telephone Number

Telephone Number of 24-Hour Facility

NORTH CAROLINA

County

Sworn to and subscribed before me this

day of _____, 20__

Signature of Notary Public

Printed Name of Notary Public

My commission expires: _____

Pursuant to G.S. 122C-262(d), this certificate *shall serve as the Custody Order* and the law enforcement officer or other authorized person *shall* provide transportation to a 24-hr. facility in accordance with G.S. 122C-251.

CC: 24-hour facility
Clerk of Court in county of receiving 24-hour facility

Note: If it cannot be reasonably anticipated that the clerk will receive the copy within 24 hours (excluding Saturday, Sunday and holidays) of the time that it was signed, the commitment examiner shall also communicate the findings to the clerk by telephone.

Seal

TO Authorized Transportation: See back side for Return of Service

RETURN OF SERVICE

Respondent WAS NOT taken into custody for the following reason:

I certify that his Order was received and served as follows:

Date and Time Respondent was Taken into Custody on

____ / ____ / ____ (MM/DD/YYYY) at ____:____ A.M. P.M.

Name of 24-Hour Facility

Date and Time Respondent was Delivered to Facility

____ / ____ / ____ (MM/DD/YYYY) at ____:____ A.M. P.M.

Date of Return

____ / ____ / ____
(MM/DD/ YYYY)

Name of Transporting Agency

Signature of Transporter