FORM 1 - Examination Certificate

(*Mental Health Act*, R.S.N.B. 1973, c.M-10, s.7.1)

New Nouveau Brunswick

Individual's date of birth:
Medicare Number:

I,_____ of_____,
(Name of Physician) *(Address)*

being a physician practising in the Province of New Brunswick, state that I personally examined

_____ of_____
(Name of Individual Examined) *(Address)*

on the _____ day of _____ , 20_____ , and made careful inquiry into all of the facts necessary to form an opinion to the nature or degree of the serious mental illness of the individual examined.

I am of the opinion the individual examined may be suffering from a serious mental illness of a nature or degree so as to require hospitalization in the interests of the individual's own safety or the safety of others and is not suitable for admission as a voluntary patient.

The facts upon which I formed my opinion as to the nature or degree of the serious mental illness are as follows:

A. Facts observed by me:

_____

_____

_____

_____

_____

B. Facts communicated to me by others (provide names and addresses):

_____

_____

_____

_____

_____

Signed this _____ day of _____ , 20 ____, at_____hours.

_____
(Signature of Physician)

NOTE: This examination certificate is not effective unless it is signed and issued by the physician within seven days after the physician examined the individual who is the subject of the examination certificate.