Form OMH 475B (9/00)

State of New York
OFFICE OF MENTAL HEALTH

CERTIFICATE OF OBSERVATION BY DIRECTOR OF COMMUNITY SERVICES (NON-PHYSICIAN)

Person's Name (Last, First, M.I.) "C" No.

....

Sex..Date of Birth..................

Address..

I, ____, hereby certify that:

a. On the __________ day of ____________________, 20____, I personally observed ________________, ____________________ who was located at ____, and in my opinion inpatient care and treatment of this person in a hospital may be appropriate.

b. It is my opinion that this person may have a mental illness which is likely to result in serious harm to himself or herself or others. By "likely to result in serious harm," I mean:

(Check appropriate statements)

☐ a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself *("other conduct" shall include the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, provided that such refusal or inability is likely to result in serious harm if there is not immediate hospitalization);*

and/or

☐ a substantial risk of physical harm to the persons, as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

c. The behavior or specific act(s) of this person on which I base my opinion is (are) described in Part A of Form 475, "Application for Involuntary Admission on Certificate of a Director of Community Services or Designee".

d. I am the Director of Community Services for the mentally disabled for the County of ____________________ ____________________, which has a population of less than 200,000 persons.

e. I am:

☐ a licensed psychologist.

or

☐ a certified social worker.

f. I believe that a hospital approved by the State Commissioner of Mental Health to admit patients pursuant to Section 9.39 of the Mental Hygiene Law is not located within 30 miles of this person.

g. I have made a reasonable effort to locate a designated examining physician but one is not immediately available. (Describe the measures taken to locate such a physician and the reason why one is not immediately available for example: unsuccessful attempt to contact by telephone or visit; unavailable due to illness, distance, medical duties, etc. if more space is needed, use reverse side.)

____

____

____

h. I believe that this person's hospital admission may be appropriate.

______________________________	____________________	__________
Signature of Director of Community Services or Designee	title	Date

______________________________	____________________
Address	Telephone Number