FORM 12-4

Certification of Admitting Physician

The undersigned does hereby certify that he/she:

1. Is a physician and surgeon licensed to practice in the State of California,
2. Is a member of the attending staff or is otherwise authorized by a facility designated by the county and approved by the California Department of Health Care Services as a facility for 72-hour treatment and evaluation,
3. Has made a physical and mental examination of the patient, considered the historical course of the patient's mental disorder, if that information was available, and
4. Believes that there is probable cause to believe that the patient is, as a result of mental health disorder:

   ☐ A danger to others ☐ A danger to himself/herself ☐ Gravely disabled

And for that reason requires hospital admission for evaluation or treatment on other than a voluntary inpatient or outpatient basis.

Date: _____ Time: _____ AM / PM

Signature: _____
(physician)

Print name: _____
(physician)

Reference: Welfare and Institutions Code Section 5150