

**PROBATE COURT OF CLERMONT COUNTY, OHIO
JAMES A. SHRIVER, JUDGE**

IN THE INTEREST OF _____

CASE NO. _____

**CERTIFICATE OF PHYSICIAN
(R.C. 5119.92 and 5119.93(C)(1))**

Affiant states that he/she is a Physician as defined in Chapter 4731 of the Ohio Revised Code.

Affiant states that he/she examined the above named Respondent on _____
(Exam must be within two days prior to the filing date of the petition which was _____.)
and based, on that examination, in his/her professional opinion, the Respondent:

- | | | |
|-------------------------------|-----------------------------------|---|
| <input type="checkbox"/> does | <input type="checkbox"/> does not | suffer from alcohol and/or drug abuse; and |
| <input type="checkbox"/> does | <input type="checkbox"/> does not | present an imminent danger or imminent threat of danger to self, family, or others if not treated; and/or |
| <input type="checkbox"/> does | <input type="checkbox"/> does not | present a substantial likelihood of such a threat in the near future; and/or |
| <input type="checkbox"/> can | <input type="checkbox"/> cannot | reasonably benefit from treatment |

The facts that support Affiant's belief that Respondent does suffer from alcohol and/or drug abuse and the need for treatment:

Type of Treatment: Inpatient Outpatient

Length of Treatment: _____

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If inpatient treatment is required, the following inpatient facilities known to the physician that are able and willing to provide the recommended inpatient treatment are as follows:

Name of Inpatient Treatment Provider

Telephone Number of Inpatient Treatment Provider

Name of Inpatient Treatment Provider

Telephone Number of Inpatient Treatment Provider

Name of Inpatient Treatment Provider

Telephone Number of Inpatient Treatment Provider

Affiant further certifies that he/she knows that the following treatment facilities are willing and able to provide the recommended outpatient treatment:

Name of Outpatient Treatment Provider

Telephone Number of Outpatient Treatment Provider

Name of Outpatient Treatment Provider

Telephone Number of Outpatient Treatment Provider

Name of Outpatient Treatment Provider

Telephone Number of Outpatient Treatment Provider

Physician's Signature

Name and Title of Physician (Please Print)

Telephone Number of Physician

License Number of Physician