Approved, SCAO

JIS CODE: AFH/PFH

STATE OF MICHIGAN PROBATE COURT COUNTY CIRCUIT COURT - FAMILY DIVISION	PETITION/APPLICATION FOR HOSPITALIZATION	FILE NO.

In the matter of _____ XXX-XX-____
Last four digits of SSN

Court ORI	Date of birth	Place of birth	Race	Sex

1. I, _____ (Name (type or print)), an adult _____ (specify whether a relative, neighbor, peace officer, etc.) petition because I believe the individual named above needs treatment.

2. The individual was born _____ (Date), has a permanent residence in _____

County at _____ (Street address, City, State, Zip)

and can presently be found at _____ (Address).

☐ This petition is for a person who was found not guilty by reason of insanity in this county.

3. I believe the individual has mental illness and

☐ a. as a result of this mental illness, the individual can be reasonably expected within the near future to intentionally or unintentionally seriously physically injure self or others, and has engaged in an act or acts or made significant threats that are substantially supportive of this expectation.

☐ b. the individual is unable to attend to those basic physical needs that must be attended to in order to avoid serious harm in the near future, and has demonstrated that inability by failing to attend to those basic physical needs.

☐ c. the individual's judgment is so impaired s/he is unable to understand the need for treatment. Continued behavior as the result of this mental illness can be reasonably expected, on the basis of competent clinical opinion, to result in significant physical harm to self or others. (If this is the only item checked, you must file this petition with the court before the person can be hospitalized.)

4. The conclusions stated above are based on
   a. my personal observation of the person doing the following acts and saying the following things:

_____

_____

_____

_____

_____

_____

(PLEASE SEE OTHER SIDE)

Do not write below this line - For court use only

b. the following conduct and statements that others have seen or heard and have told me about:

_____

_____

_____

by: _____
Witness name Complete address Telephone no.

_____

_____

_____

by: _____
Witness name Complete address Telephone no.

5. The persons interested in these proceedings are:

NAME	RELATIONSHIP	ADDRESS	TELEPHONE
	Spouse		
	Guardian*		

*(Specify the county where the guardianship was established and the case number.) _____

6. The individual ☐ is ☐ is not a veteran.

7. **I request** the court to determine the individual to be a person requiring treatment and that s/he be hospitalized until the hearing.

I declare under the penalties of perjury that this petition/application has been examined by me and that its contents are true to the best of my information, knowledge, and belief.

_____
Signature of attorney

_____
Name (type or print) Bar no.

_____
Address

_____
City, state, zip Telephone no.

_____
Date

_____
Signature of petitioner

_____
Address

_____
City, state, zip

_____ _____
Home telephone no. Work telephone no.

Attached is a
☐ clinical certificate by physician or licensed psychologist taken within the last 72 hours.
☐ clinical certificate by psychiatrist taken within the last 72 hours.
☐ petition/affidavit for examination (PCM 209 or PCM 209a) because examination could not be secured.

This Application for Hospitalization was filed with the hospital on _____ at _____ m.

FOR HOSPITAL USE ONLY

_____
Signature of hospital representative