

STATE OF MICHIGAN PROBATE COURT COUNTY OF	SUPPLEMENT TO CLINICAL CERTIFICATE ON APPEAL OF RETURN TO HOSPITAL/FACILITY	FILE NO.
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In the matter of _____
First, middle, and last name

Attached is my clinical certificate (form PCM 208) setting forth why the above person requires treatment. I further certify and report as follows.

1. The reason(s) for this individual's return to the hospital or facility from authorized leave, and the need for treatment in a hospital or facility are _____

2. The plans for further treatment of the individual are _____

3. Should the court rule against the return of this individual, I recommend the court consider the following alternatives instead of a return to authorized leave status, if any of these options are available.

- | | |
|---|--|
| <input type="checkbox"/> Day treatment in a hospital or facility | <input type="checkbox"/> Night treatment in a hospital or facility |
| <input type="checkbox"/> Residential placement | <input type="checkbox"/> Custody of a friend or relative |
| <input type="checkbox"/> Inpatient treatment at a private psychiatric hospital, at a general hospital's psychiatric unit, or a private residential facility | <input type="checkbox"/> Assisted outpatient treatment |
| | <input type="checkbox"/> Home care or homemaker service |
| | <input type="checkbox"/> Day activity programs |

Other: _____

None of the above merits exploration. _____
State reasons

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

Date Signature Title (physician, psychiatrist, licensed psychologist)

Do not write below this line - For court use only