Form 3
Medical Certificate for Involuntary Psychiatric Assessment - Part 2

(Subsection 10(2) - *Involuntary Psychiatric Treatment Act*)

I, Dr.____*(full name)*, a physician, signed the attached

Medical Certificate for Involuntary Psychiatric Assessment - Part 1 for

____ *(full name of person)*.

I hereby certify that compelling circumstances exist for the involuntary psychiatric assessment of this person and that a second physician is not readily available to examine the person and complete a second Medical Certificate for Involuntary Psychiatric Assessment - Part 1.

________________________ *(dd/mm/yyyy)*
(date of signature)

____
(signature of physician)

____________________ ☐ a.m.
(time of signature) ☐ p.m.

____
(physician's name - printed)

Note*:*

This form must be accompanied by a Medical Certificate for Involuntary Psychiatric Assessment - Part 1 (Form 2) signed by the same physician.