Form 8
Certificate of Cancellation of Leave
(Section 44 - Involuntary Psychiatric Treatment Act)

I, Dr. ____________________________ (full name), a psychiatrist on the staff of ____________________________ (name of psychiatric facility), am the psychiatrist for ____________________________ (full name of patient), an involuntary patient who is currently living outside of the psychiatric facility on a certificate of leave.

I am cancelling the patient’s certificate of leave dated __________________________ effective the date of this certificate of cancellation of leave because I have knowledge that (check all that apply)

- the patient has breached a condition of their certificate of leave
- the patient’s condition may present a danger to the patient or others
- the patient has failed to report as required by their certificate of leave

_________________________ __________________________
(date of signature) (signature of psychiatrist)
_________________________ __________________________
(psychiatrist’s name - printed)

Note:
This form authorizes a peace officer for up to 30 days after the date it is signed to take the patient into custody and to a psychiatric facility for an involuntary psychiatric assessment.