MENTAL HEALTH ACT, 2012
ELEVENTH SCHEDULE
[Article 24(4) and (6)]

Mental Health Act

This certificate shall be forwarded to the Commissioner within 24 hours of certification.

CLMC Ref No:

CERTIFICATION
OF LACK OF MENTAL CAPACITY

To the Commissioner for the Promotion of Rights of Persons with Mental Disorders.

To be filled by a specialist in mental health.

(1) I the undersigned, a specialist in mental health have personally reviewed:

(Surname) (Name) (ID No) (D.O.B) (Sex) (M / F)

of (address) ____________________________________________________

____________________________________________________

and certify that the above named person lacks mental capacity.

(2) The reasons for such decision are:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

(3) In my opinion, this person lacks mental capacity to take rational decisions regarding:

________________________________________________________________________

________________________________________________________________________

(4) Estimated duration of lack of mental capacity is

□ __________ (weeks) and an application for incapacitation or interdiction is not recommended; OR

□ more than 26 weeks and an application for incapacitation is recommended; OR

□ more than 26 weeks and an application for interdiction is recommended.

(5) If applicable, indicate if person is:

□ a voluntary patient __________

□ an involuntary patient under an Involuntary Admission for Observation

IAO Ref No __________

□ an involuntary patient under an Involuntary Admission for Treatment Order

IATO Ref No __________

□ an involuntary patient under an Extension of Involuntary Admission for Treatment Order

EIATO Ref No __________

□ an involuntary patient under a Continuing Detention Order

CDO Ref No __________

□ an involuntary patient under a Community Treatment Order

CTO Ref No __________

(6) Is this a new application?
<table>
<thead>
<tr>
<th>□ YES</th>
<th>□ NO</th>
<th>CLMC Ref No: ________ which should now be revoked</th>
</tr>
</thead>
</table>

(7) The responsible carer is:

<table>
<thead>
<tr>
<th>(Surname)</th>
<th>(Name)</th>
<th>(ID No)</th>
<th>(D.O.B)</th>
<th>M/F</th>
<th>(Sex)</th>
</tr>
</thead>
</table>

of (address) ___________________________________________________________________________


(Official Stamp) __________ (Signature) __________ (Reg. No) __________

(Date) __________ (Time) __________

To be filled by Commissioner

Certification received on (date) ________________ at (time) _______________

□ Dr _______________ an independent specialist is appointed and notified to review person in terms of the Mental Health Act and is to submit his/her opinion by (date) ________________

(Signature) __________ (Date) __________ (Time) __________

To be filled by independent specialist in mental health appointed by Commissioner

I the undersigned, a specialist in mental health appointed by the Commissioner to review ______________________ ID No __________ certify that:

(a) I am not the responsible specialist for the named person

(b) I have reviewed the person for whom this certification is being made and

□ I agree with the certification of lack of mental capacity;

□ I disagree with the certification of lack of mental capacity for the following reasons:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

□ I agree with the certification of lack of mental capacity but have the following reservations (specify):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

(Official Stamp) __________ (Signature) __________ (Reg. No) __________

(Date) __________ (Time) __________

To be filled by

□ Independent specialist opinion received on (date) ________________ at
Commissioner (time) __________________

DECISION

☐ Certification approved for a period of ________ (weeks) and shall expire on ____________

☐ Certification approved for a period of ________ (weeks) and shall expire on ____________ with the following amendments:
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________

☐ Certification for more than 26 weeks and a recommendation for an application for incapacitation are approved

☐ Certification for more than 26 weeks and a recommendation for an application for interdiction are approved.

☐ CLMC Ref No: _________ is revoked (if applicable)

☐ Certification not approved

☐ CLMC Ref No: _________ is not revoked (if applicable)

My decision was communicated in writing to the responsible specialist, the person, and the responsible carer on (date) ____________________.

__________________________________  ____________________  ________________
(Signature)  (Date)  (Time)