Form OMH 471A (2-94)

State of New York
Office of Mental Health

CERTIFICATE OF EXAMINING PHYSICIAN

To Support an Application for Involuntary Admission

Person's Name (Last, First, M.I.): Saunders, Kevin E.

Sex: M Date of Birth: 5/1/56

Address: 1668 Trumansburg Rd.

CERTIFICATION

I, DONALD J. BAKER, hereby certify that:
(Name of Examining Physician)

1. I am a physician licensed to practice medicine in New York State.
2. I have with care and diligence personally examined the above named person on: 04 (MO.) 04 (DAY) 03 (YEAR) at CAYUGA MEDICAL CENTER
(place where examined)
3. I find:
   a. this person is in need of involuntary care and treatment in a hospital providing inpatient services for the mentally ill *("in need of involuntary care and treatment" means that the person has a mental illness for which care and treatment as a patient in a hospital is essential to such person's welfare and whose judgment is so impaired that he or she is unable to understand the need for such care and treatment)*; and
   b. as a result of his or her mental illness, this person poses a substantial threat of harm to self or others *("substantial threat of harm" may encompass (i) the person's refusal or inability to meet his or her essential need for food, shelter, clothing, or health care, or (ii) the person's history of dangerous conduct associated with non-compliance with mental health treatment programs)*.
4. I have formed my opinion on the basis of facts and information I have obtained (described below and on the reverse side) and my examination of this person.
5. I have considered alternative forms of care and treatment but believe that they are inadequate to provide for the needs of this person, or are not available.
6. If this person has to my knowledge received prior treatment, I have, insofar as possible, consulted with the physician or psychologist furnishing such prior treatment.
7. To the best of my knowledge and belief, the facts stated and information contained in this certificate are true.

Signature	Print Name Signed	Title
[signature]	DONALD J. BAKER	MD, ED
Address	**Phone Number**	**Date** (Mo. / Day / Yr.) / **Time** (Hr. / Min. / AM PM)
101 Dates Dr. Ithaca NY	607-274-4411	4 / 4 / 03 / 1340 / AM PM

- Agitated, confused, delusional
- Severely impaired judgment
- Unable to care for self - danger to self.

[signature]