

Individual's Signature/Date/Time

Patient Received Copy of decision

SECOND LEVEL APPEAL FAX or EMAIL TO OMHSAS MEDICAL DIRECTOR

I request to appeal the Committee's decision concerning forced administration of medication to the OMHSAS Medical Director:

Individual's Signature/Date/Time

Questions/Concerns? Please contact the External Advocate

Client Rights Representative Signature/Date/Time

Final Decision (if additional hearing held, date included):

OMHSAS Medical Director Signature

Patient Received Copy