

**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.

\_\_\_\_\_  
(date of signature)

\_\_\_\_\_  
(signature of physician)

\_\_\_\_\_ a.m./p.m.  
(time of signature)

\_\_\_\_\_  
(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.