



and who is believed to be in need of supervision, care and treatment because of the following facts:\_\_\_\_\_

3.. The conclusion that the person has a mental disorder is based on the following facts:

4. The conclusion that the person is dangerous or disabled is based on the following facts:

**PERSONAL DATA OF PROPOSED PATIENT:**

Age\_\_\_\_\_ Date of Birth\_\_\_\_\_ Sex\_\_\_\_\_ Race\_\_\_\_\_

Weight\_\_\_\_\_ Height\_\_\_\_\_ Hair Color \_\_\_\_\_ Eye Color\_\_\_\_\_

Marital Status\_\_\_\_\_ Number of Children\_\_\_\_\_

Social Security Number\_\_\_\_\_ Religion\_\_\_\_\_

Distinguishing Marks\_\_\_\_\_

Occupation\_\_\_\_\_

Present Location\_\_\_\_\_

Dates and Places of Previous Hospitalization\_\_\_\_\_

How Long in Arizona \_\_\_\_\_ State Last From \_\_\_\_\_

Veteran \_\_\_\_\_ C-No. \_\_\_\_\_ Education \_\_\_\_\_

NAME ADDRESS AND TELEPHONE NUMBER OF:

1) Guardian\_\_\_\_\_

2) Spouse\_\_\_\_\_

3) Next of Kin\_\_\_\_\_

4) Significant Other Persons\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF APPLICANT

Printed or Typed name of Applicant\_\_\_\_\_

Relationship to Proposed Patient\_\_\_\_\_

Applicant's Address\_\_\_\_\_

Applicant's Telephone\_\_\_\_\_

SUBSCRIBED AND SWORN to before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public

My Commission Expires:

\_\_\_\_\_