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:** _____ _____ _____ _____ _M / F_ _____ **(Surname) (Name) (ID No) (D.O.B) (Sex) (Ward)** **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?**

	□ YES **□ NO CLMC Ref No: _____ which should now be revoked** **(7) The responsible carer is:** **_____ _____ _____ _____ _M / F__** **(Surname) (Name) (ID No) (D.O.B) (Sex)** **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)**