

IN THE CIRCUIT COURT OF THE NINETEENTH JUDICIAL CIRCUIT
IN AND FOR INDIAN RIVER COUNTY, FLORIDA

IN RE: _____ CASE NO.: _____

Petition and Affidavit Seeking Ex Parte Order Requiring Involuntary Examination

I, _____ being duly sworn, am filing this sworn statement requesting a court order
Print Name of Petitioner
for the involuntary examination of _____ (hereinafter referred to as PERSON).
Print Name of Person

This petition and affidavit will be included in the PERSON's clinical record and may be viewed by the PERSON.

I understand that, by filling out this form, the PERSON may be taken by law enforcement to a mental health facility for an examination.

I SWEAR that the answers to the following questions are given honestly, in good faith, and to the best of my knowledge.

1. a. I live at: (print your full residence address and phone number) Phone: _____

Street Address City State Zip Code

b. I work as a: (Occupation) _____ Work Phone: _____

Work Street Address City State Zip Code

c. The PERSON lives at, or may be found at, the following address(es):

Street Address: _____ City: _____

Street Address: _____ City: _____

Street Address: _____ City: _____

2. I have the following relationship with the PERSON: _____

3. Check the one box that applies:

a. I or a family member have or have not previously made allegations to law enforcement involving this PERSON on (date) _____ such as domestic violence, trespassing, battery, child abuse or neglect, Baker Act, neighborhood disputes, etc., as described:
Date (mm/dd/yyyy)

b. This PERSON has or has not previously made allegations to law enforcement about me or my family on (date) _____ such as domestic violence, trespassing, battery, child abuse or neglect, Baker Act, etc., as described:
Date (mm/dd/yyyy)

4. Check the one box that applies:

a. I or a family member are not now, and have not in the past, been involved in a court case with the PERSON.

b. I or a family member am now, or was, involved in a court case with the PERSON. This case is/was a

_____ in _____
Type of Case When

Explain: _____

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12. I believe that the PERSON is unable to determine for himself/herself, why the examination is necessary because:

13. I believe that the PERSON has a mental illness which will keep the PERSON from being able to meet the ordinary demands of living because:

14. I believe that without care or treatment, the PERSON is likely to suffer from neglect or refuse to care for himself/herself, because:

15. I believe that this lack of care or neglect will lead to the PERSON hurting himself or herself because:

16. Can family or close friends now provide enough care to avoid harm to the PERSON? Yes No
If not, why?

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Provide the following identifying information about the person (if known) if it is determined necessary to take the person into custody for examination:			
County of Residence:		Date Of Birth:	Age:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Race:	Attach a picture of the PERSON if possible. Picture attached: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Height:	Weight:	Hair Color:	Eye Color:
Does the PERSON have access to any weapons? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:			
Is the PERSON violent now? <input type="checkbox"/> No <input type="checkbox"/> Yes Has the PERSON been violent in the recent past: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:			
Does the PERSON have any pending criminal charges against him/her? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe:			
GUARDIANSHIP:			
1) Does the PERSON have a legal guardian? <input type="checkbox"/> No <input type="checkbox"/> Yes			
2) Is there a pending petition to determine the PERSON's capacity and for the appointment of a guardian? <input type="checkbox"/> No <input type="checkbox"/> Yes If YES to either of the above, provide the name, address and phone number of the current or proposed guardian.			
Name: _____		Phone: _____	
Address (including city and zip): _____			
PHYSICIAN: Name: _____		Phone: _____	
MEDICATIONS: Provide name of medications if known: _____			
CASE MANAGEMENT: Provide name and phone number of case manager or case management agency, if known: _____			

I understand that this sworn statement is given under oath and will be treated as though it was made before a judge in a court of law. I understand that any information in this sworn statement which is not to the best of my knowledge and done in good faith may expose me to a penalty for perjury and other possible penalties under the statutes of the State of Florida.

Under penalties of perjury, I declare that I have read the foregoing document and that the facts stated in it are true.

Signature of Affiant/Petitioner: _____

SWORN TO AND SUBSCRIBED before me
this ____ day of (mon/yr) _____
by _____ who is personally known
to me or presented _____ as identification.

Notary Public – State of Florida
My Commission expires on _____
Date

OR

SWORN TO AND SUBSCRIBED before me
this ____ day of (mon/yr) _____
Clerk of Circuit Court for Indian River County, Florida

By: _____
Deputy Clerk

A copy of the petition(s) must be attached to an Ex Parte Order for Involuntary Examination and accompany the person to the receiving facility.