



CERTIFICATE OF RENEWAL

Form 4 The Mental Health Act, 1967 Section 13(1)

I, the undersigned physician, hereby certify that on the _____ day of _____, 19____,
I personally examined _____
(name of patient in full)

(home address)

After making due inquiry into all the facts necessary for me to form a satisfactory opinion, I do hereby further certify that he/she suffers from mental disorder of a nature or degree so as to require further hospitalization in the interests of his/her own safety or the safety of others.

State reason(s) why the above-named person is not suitable to be continued as an informal patient:

*Renewal because of relapse on Oct 21/70.
Condition unchanged.*

Signed this *23* day of *November*, 19*70*

(Signature of attending physician)

In accordance with The Mental Health Act, 1967, this certificate shall be effective from the *26th* day of *November*, 19*70*, and shall remain in force for a period of *4* months.