NOTICE OF EXPIRATION

TO: _____ Clinical Team Leader or Supervisor

_____ Community Rehabilitation Specialist

_____ Treating Psychiatrist

FROM: _____
Community Support Services, Inc.
150 Cross Street
Akron, OH 44311

RE: Outpatient Commitment for _____

DATE: _____

The above-named individual's outpatient commitment to the ADM Board is expiring. The treatment team will need to decide if they wish this individual to have another term of commitment. If you feel outpatient commitment is still appropriate and beneficial for this individual, the treating psychiatrist must complete an Application for Recommitment and return to me no later than ____/____/____. (NOTE: Blank application form has been sent to the treating psychiatrist) Please be aware that the Community Rehabilitation Specialist and treating psychiatrist will be subpoenaed to testify at the recommitment hearing.

If it is decided not to pursue another term of commitment, please sign below.

_____ Another term of commitment is not being requested.

_____
Signature, Treating Psychiatrist