SUPERIOR COURT OF CALIFORNIA COUNTY OF LOS ANGELES	Reserved for Clerk's File Stamp
HOSPITAL / FACILITY NAME, ADDRESS, & UNIT:	
REQUEST FOR MENTAL HEALTH FACILITY-BASED HEARING	CASE NUMBER:

Patient's Name:

Preferred language for patient (if other than English):

Booking number (if applicable):

Hearing Type:

☐ **Certification Review Hearing** (WIC 5150)
Date of the hold:

☐ **Certification Review Hearing** (WIC 5250)
Date of the hold:

☐ **Certification Review Hearing** (WIC 5270)
Date of the hold:

☐ **Medication Capacity Hearing** (WIC 5332 – 5334)
Requested hearing time:
☐ 9:30 am-11:00 am
☐ 2:30 pm-4:00 pm

☐ **In re Roger S. Hearing**

Date:

Hospital Representative:

Telephone Number: