

IN THE CIRCUIT COURT OF _____ COUNTY, WEST VIRGINIA

IN RE: _____ Case No.: -P -

*[Name of Licensed Professional Counselor, Name of
Licensed Independent Clinical Social Worker, Advanced
Nurse Practitioner with Psychiatric Certification, or
Physician Assistant]*

Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

**PETITION FOR COURT AUTHORIZATION
TO PERFORM EXAMINATIONS FOR PROBABLE CAUSE PROCEEDINGS FOR
INVOLUNTARY HOSPITALIZATION**

W. Va. Code: §27-5-2(e)

On this _____ day of _____ *[month]*, _____ *[year]*, comes the above named
Licensed Professional Counselor (WV LPC License # _____) and/or
Licensed Independent Clinical Social Worker (WV SW License #: _____)
and/or Advanced Nurse Practitioner with Psychiatric Certification (WV RN License #: _____)
and/or Physician Assistant (WV License #: _____) (*hereinafter referred to
as "Petitioner"*) and petitions the Court pursuant to West Virginia Code § 27-5-2(e) for authorization to perform
examinations for probable cause proceedings for involuntary hospitalization.

Attached for the Court's review and consideration is/are Petitioner's current and valid license(s):
[Petitioner MUST attach a copy of the applicable license(s) identified below. Check appropriate box(es).]

A copy of Petitioner's license as a Professional Counselor issued by the West Virginia Board of
Examiners in Counseling pursuant to the provisions of West Virginia Code §§ 30-30-1, et. seq.

**Note: Licensing will be verified in good standing by contacting the West Virginia Board of Examiners in
Counseling at (304) 558-5494, or at 815 Quarrier Street, Suite 212, Charleston, WV 25301.**

A copy of Petitioner's license as an Independent Clinical Social Worker issued by the West Virginia Board of
Social Work Examiners pursuant to the provisions of West Virginia Code §§ 30-30-1, et. seq.

**Note: Licensing will be verified in good standing by contacting the West Virginia Board of Social Work
Examiners at (304) 440-4980, or at P.O. Box 5459, Charleston, WV 25361.**

A copy of Petitioner's license as a Registered Professional Nurse with Psychiatric Certification and Letter of
Recognition as an Advanced Nurse Practitioner issued by the West Virginia Board of Examiners for Registered
Professional Nurses pursuant to the provisions of West Virginia Code §§ 30-7-1, et seq., and §§ 19-7-1, et. seq.,
Title 19, Series 7, Legislative Rules of the West Virginia Board of Examiners for Registered Professional Nurses.

[Initial all applicable certifications below and provide information requested.]

_____ Adult Psychiatric and Mental Health Nurse Practitioner
Certification #: _____; Expiration Date: _____

_____ Clinical Specialist in Adult Psychiatric and Mental Health Nursing
Certification #: _____; Expiration Date: _____

_____ Clinical Specialist in Child and Adolescent Psychiatric and Mental Health Nursing
Certification #: _____; Expiration Date: _____

_____ Other Psychiatric Certification: *[insert name of certification]*

Certification #: _____; Expiration Date: _____

Note: Nursing License and Certifications will be verified in good standing by contacting West Virginia Board of Examiners for Registered Professional Nurses at (304) 744-0900, fax (304) 744-0600, or at 90 MacCorkle Ave., S.W., Suite 203, South Charleston, WV 25303.

A copy of Petitioner's license as a Physician Assistant issued by the West Virginia Board of Medicine pursuant to the provisions of West Virginia Code §§ 30-3E-1, et. seq. and/or issued by the West Virginia Board of Osteopathy pursuant to the provisions of West Virginia Code §§ 30-14A-1, et. seq.

Petitioner also includes for the Court's consideration the following educational information: ***[Check all applicable boxes and complete the requested information. At least one MUST be completed.]***

Masters Degree in Counseling was obtained from _____ *[insert name of college/university]*
on _____ *[insert date degree awarded: mm/dd/yyyy]*.

Masters Degree in Nursing was obtained from _____ *[insert name of college/university]*
on _____ *[insert date degree awarded: mm/dd/yyyy]*.

Masters Degree in Social Work was obtained from _____ *[insert name of college/university]*
on _____ *[insert date degree awarded: mm/dd/yyyy]*.

Doctorate Degree in Social Work was obtained from _____ *[insert name of college/university]*
on _____ *[insert date degree awarded: mm/dd/yyyy]*.

Baccalaureate Degree in Primary Health Care or Surgery from _____ *[insert name of college/university]*
on _____ *[insert date degree awarded: mm/dd/yyyy]*.

Masters Degree in Primary Health Care or Surgery from _____ *[insert name of college/university]*
on _____ *[insert date degree awarded: mm/dd/yyyy]*.

Petitioner also includes the following additional information which establishes particularized expertise by Petitioner in the area of MENTAL HEALTH: *[add additional pages as needed]*

Petitioner also includes for the Court's consideration the following evidence of particularized expertise in the area of ADDICTION. Petitioner holds the following addiction certifications from the:

[Initial all applicable addiction certifications and provide information requested.]

_____ West Virginia Board for Addiction and Prevention Professionals as a:

[check appropriate box(es) and provide information requested.]

CCAC (Certified Clinical Addiction Counselor)

Certification #: _____; Expiration Date: _____

CAC (Certified Addictions Counselor)

Certification #: _____; Expiration Date: _____

CPSII (Certified Prevention Specialist Level II)

Certification #: _____; Expiration Date: _____

Other: *[Describe]* _____

Certification #: _____; Expiration Date: _____

Summary of Certification Requirements: _____

Note: Certifications will be verified in good standing by contacting West Virginia Certification Board for Addiction and Prevention Professionals at (304) 768-2942, fax (681) 205-8503, or at 436 12th Street, Suite C, Dunbar, WV 25064.

_____ IC&RC/AODA (The International Certification & Reciprocity Consortium/Alcohol and Other Drug Abuse) as an *[check appropriate box(es) and provided information requested.]*

AAODA (Advanced Alcohol and Drug Counselor)

Certification #: _____; Expiration Date: _____

AODA (Alcohol and Drug Counselor)

Certification #: _____; Expiration Date: _____

Other: *[Describe]* _____

Certification #: _____; Expiration Date: _____

Summary of Certification Requirements: _____

Note: Certifications will be verified in good standing by contacting NAADAC at (703) 741-7686, fax (703) 741-7698, or at 44 Canal Center Plaza, Suite 301, Alexandria, VA 22314.

Petitioner *[check appropriate box]* HAS HAS NOT, attended an orientation training on mental hygiene/involuntary commitment/proceedings for involuntary custody for examination provided by The West Virginia Supreme Court of Appeals, or a similar course/training on West Virginia's law provided by another institution or organization. If Petitioner has attended such a course/training, attached is a copy of the Certificate of Attendance issued by the institution or organization offering said course/training. The date of attendance was _____ - _____, and the number of course/continuing education hours were _____.

The institution or organization providing/sponsoring the course/training was: *[Provide name and contact information for the institution/organization]*

Name of Institution/Organization: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Fax Number:** _____

Petitioner includes for the Court's consideration the following additional information which establishes particularized expertise by Petitioner in the area of mental hygiene/involuntary commitment/proceedings for involuntary custody for examination: *[add additional pages as needed]*

Petitioner understands that the community mental health center designated by the secretary of the department of health and human resources to serve this county must provide or arrange for examinations for involuntary hospitalization proceedings (West Virginia Code § 27-5-2(e)).

VERIFICATION

I, _____, the Petitioner, after making an oath or affirmation to tell the truth, certify, UNDER PENALTIES OF FALSE SWEARING as provided by law, that the information and statements contained in this Petition and the _____ *[insert number]* of additional pages added hereto are true and accurate to the best of my knowledge, information and belief, that any and all attached copies are true and accurate copies of the originals. I understand that if I knowingly provide FALSE information in this Petition, I could be subject to a criminal charge of false swearing.

Date

Time

Signature

The foregoing Petition and Verification was sworn to or affirmed before me on the _____ day of _____ *[month]*, _____ *[year]*.

Notary Public

My commission expires: _____

CONTINUATION SHEET

Use this sheet to enter information that would not fit in the space(s) provided above. Label each response.

[illegible]