

DEPARTMENT OF HEALTH

REPORT ON EXPLOITATION, PHYSICAL OR OTHER ABUSE, NEGLECT OR DEGRADING TREATMENT OF A MENTAL HEALTH CARE USER [Section 11(2) of the Act]

(All the information contained in this Form will be held strictly confidential).

I..... (name/s)

..... (address)

I hereby declare that I have witnessed exploitation, physical or other abuse, neglect or degrading treatment of the following mental health care user:

I hereby declare that I have been through exploitation, physical or other abuse, neglect or degrading treatment

A. Details of User (where known)

First Name and Surname of User.....

Date of birth or estimated age

Gender: Male [] Female []

Occupation Marital status: S [] M [] D [] W []

Residential address:
.....
.....
.....

B. Name of health establishment or other place where the alleged incident occurred

Address:
.....
.....
.....

C. Date of incident

D. Brief description of the User:

E. Description of the alleged incident:

.....

.....

Print initials and surname

Contact number:.....

Signature under oath:.....
 (person who witnessed alleged incident)

Date:

OATH/AFFIRMATION

I certify that:

- i. The deponent acknowledged to me that:
 - a. He/she knows and understands the contents of this declaration;
 - b. He/she has no objection to taking the prescribed oath;
 - c. He/she considers the prescribed oath to be binding on his/her conscience;
- ii. The deponent signed this declaration in my presence at on this day of 20.....

 Signature: Commissioner of Oath: Ex-Officio
 Name:
 Rank / Designation:

[Original to be submitted to the relevant Mental Health Review Board]