Notification of Involuntary Medication Committee Hearing

Date: _____

To: _____ _____
Offender Name ID #

From: _____ Mental Health Unit Manager

RE: Mental Health Involuntary Medication Due Process Committee Hearing

This is to advise you that the Mental Health Involuntary Medication Due Process Committee will meet on _____ at _____ hours in the following location: _____. The Committee will discuss the involuntary medication order prescribed by _____, MD on _____. The purpose of the meeting is to determine whether the criteria, as set forth in Georgia Department of Corrections, Standard Operating Procedure 508.26 was met prior to the administration of the involuntary medication. The Committee will also decide whether conditions for continuation of the involuntary medication order have been met.

You have specific rights as outlined by the assigned Advocate. You have the right to comply with the medication order voluntarily, prior to the Committee meeting by signing a Medication Consent form. You have the right to receive, in writing, the results of the Committee proceedings. Also, you may be represented by private legal counsel at your expense. An Advocate will be appointed to assist you. You may appear before the Committee to explain your reason for refusing the medication.

A representative from the Mental Health Staff, _____, has been appointed to assist you as your Advocate. The assistance of this staff member will be limited to helping you to verbalize your reason for refusal of the medication.

Retention Schedule: Completed forms shall be given to the Offender (original), a copy placed in the offender's mental health file (section 5) and medical file (section 5). At the end of the offender's need for mental health services and/or sentence, the mental health file shall be placed within the offender's health record and retained for 10 years.