

## Notification of Involuntary Medication Committee Decision

Date: \_\_\_\_\_

To: \_\_\_\_\_  
Offender Name ID #

From: \_\_\_\_\_  
Mental Health Unit Manager Facility

RE: Decision of Mental Health Involuntary Medication Due Process

This is to advise you that the Mental Health Involuntary Due Process Committee met  
on \_\_\_\_\_ at \_\_\_\_\_ hours and made the following finding:  
(date) (time)

- [ ] You met criteria for involuntary medication administration. The medication will continue to be administered involuntarily until your physician determines that it is no longer necessary. This decision may be reviewed through a rehearing in six (6) months.
- [ ] You did not meet criteria for involuntary medication administration. The involuntary administration of the medication will be discontinued. Your physician may continue to offer medication to you on a voluntary basis.

Cc: \_\_\_\_\_  
(Offender Advocate)