

ATTORNEY OR PARTY WITHOUT ATTORNEY ( <i>Name, State Bar number, and address</i> )  TELEPHONE NO.: _____ FAX NO. ( <i>Optional</i> ): _____ E-MAIL ADDRESS ( <i>Optional</i> ): _____ ATTORNEY FOR ( <i>Name</i> ): _____	<b>FOR COURT USE ONLY</b>
<b>SUPERIOR COURT OF CALIFORNIA, ALAMEDA COUNTY</b>  STREET ADDRESS: MAILING ADDRESS: CITY AND ZIP CODE: BRANCH NAME	
PETITIONER/PLAINTIFF: RESPONDENT/DEFENDANT: OTHER:	
<b>RECOMMENDATION, CERTIFICATION, AND ORDER FOR MEDICAL,                  SURGICAL, DENTAL, OR OTHER REMEDIAL CARE</b>	CASE NUMBER: _____

1. I (*Name*): \_\_\_\_\_ declare that I am a duly licensed physician or dentist under the laws of the state.  
 My telephone number is: \_\_\_\_\_ ; my fax number is: \_\_\_\_\_

2.  I recommend that immunization, medical and dental examination, preventive, therapeutic and remedial medical and dental procedures, and psychiatric or psychological evaluation and treatment be provided to the minor who is the subject of this action as may be deemed necessary or advisable in accordance with sound medical or dental practice.

3.  I recommend that the following  major OR  minor surgical procedure(s) be performed (*specify*):

4. The minor's current condition that necessitates the treatment is (*specify*):

5. The following consequences are to be expected if this treatment is not provided (*specify*):

6. The risks of the treatment are: (*specify*):

Date: \_\_\_\_\_ \_\_\_\_\_  
 PHYSICIAN     DENTIST     OTHER (*specify*): \_\_\_\_\_

7. The undersigned  Child Welfare Worker OR  Deputy Probation Officer certifies as follows:

a. The parents, guardians, and/or caretakers of the minor are:

Mother or partner:

Father or partner:

Guardian:

Caretaker:

b.  The whereabouts of the parent, guardian, or caretaker are unknown and the following efforts have been made to locate them (specify):

c.  The parent, guardian, or caretaker is incapable of authorizing the treatment for the following reasons (specify):

d.  The parent, guardian, or caretaker is unwilling to authorize the treatment for the following reasons (specify):

e.  This matter has been set for a hearing on (specify):

f.  Notice of the application and hearing, if any, has been given or attempted as follows (attach separate sheet if necessary to describe attempts to provide notice) (specify):

e.  Parental rights for the minor were terminated on (Specify date): \_\_\_\_\_ in action (Specify case number): \_\_\_\_\_

Date:



\_\_\_\_\_

CHILD WELFARE WORKER     DEPUTY PROBATION OFFICER     OTHER (specify): \_\_\_\_\_

QIC: \_\_\_\_\_

PHONE: \_\_\_\_\_

Date:



\_\_\_\_\_

ATTORNEY FOR MINOR

8. The order for medical or dental care and treatment that has been recommended is  GRANTED  DENIED.

9.  It is hereby ordered that the aforementioned physician or dentist is authorized to administer the medical, dental, surgical, or other remedial care for the minor as is described and recommended by the practitioner.

Date:

\_\_\_\_\_

(JUDICIAL OFFICER)