

NOTICE OF PARTICIPATION IN TREATMENT COURT

This notice is to verify that _____ is currently participating in
Participant Name
the Alternative Sentencing Court IV.

As a participant, any use of physician prescribed or over the counter medication is not allowed without the knowledge and consent of the Alternative Sentencing Court IV and monitoring and supervision by treatment providers and/or probation officer.

We would request that you take this into account when prescribing or recommending medication. The undersigned participant and the Alternative Sentencing Court IV greatly appreciate your consideration of these restrictions as you provide medical or dental treatment to this patient. Please feel free to contact _____ at _____
Treatment Court Representative Phone Number
to discuss any issues relating to this patient and their supervised treatment.

Signature of Participant

Date

Signature of Treatment Court Representative

Date

We request that you sign below for our records to ensure our participants are fulfilling their responsibility to the Court and to their medical provider by disclosing this information. Thank you.

Attending Physician/Nurse Practitioner/Dentist

Date