Mental Health Certification For Firearm Possession

(Mental Health Admission More than 5 years ago)

Pursuant to: 430 ILCS 65/4(a)(2)(iv) and 430 ILCS 65/8(u)

Instructions: This certification form must be completed and returned by an Illinois licensed physician, clinical psychologist or qualified examiner as defined in 405 ILCS 5/1-122 (hereinafter referred to as "Evaluator") and **returned directly to** the:

Illinois State Police
Firearms Record Challenge Unit
801 South Seventh Street, Suite 400-M
Springfield, Illinois 62703-2487

1. The Evaluator completing this form must have:
   - ***First,*** reviewed all collateral mental health information supplied by the applicant and others, and
   - ***Then,*** performed a mental health evaluation of the petitioner prior to completing the form.
2. ***Do not*** give the original form to the petitioner; please, mail it ***directly*** to the Illinois State Police.

NAME OF FOID CARD PETITIONER:____ **DATE OF BIRTH:**_____/____/______
Last, First, Middle Initial

Certification of Evaluator

By my signature below, I affirm:

- I am a physician, clinical psychologist or qualified examiner as defined in 405 ILCS 5/1-122;
- I have reviewed all documentation provided, and I have consulted relevant collateral sources;
- I have administered (or overseen the administration of) the mental health evaluation of the petitioner;
- I have personally assessed this petitioner for risk of suicidal or homicidal ideation and/or any threat of violence to their intimate partner, family, self, and others; and
- I have determined with a reasonable degree of medical certainty:

1. The petitioner is a serious threat of physical violence against a reasonably identifiable victim.	☐ YES ☐ NO
2. The petitioner poses a clear and imminent risk of serious physical injury to themselves or another person.	☐ YES ☐ NO
3. The petitioner demonstrates threatening physical or verbal behavior, such as violent, suicidal, or assaultive threats, actions, or other behavior.	☐ YES ☐ NO

4. Explanation/Comments:

Evaluator

Name of evaluator (please print):	**Signature:**	Date:
Professional License #:	State of Issuance:	NPI#:
Printed Address:	Telephone (voice):	Fax: