

CANADA
PROVINCE OF SASKATCHEWAN

I, the undersigned

(name in full and qualifications)

a duly qualified medical practitioner, being the attending physician responsible for the care and treatment

of

*(name of patient)*hereby revoke any certificate issued pursuant to section 24 of *The Mental Health Services Act* that is in effect on this date on the following grounds:_____
Date *(dd/mm/yy)*_____
Signature of physician

Distribution

1. Mental health centre
2. Official representative
3. Officer in charge