Involuntary Electroconvulsive Treatment (ECT) Review Committee
Physician Appointment Request

Name of Physician Requesting Appointment: _____

Program/Facility Name: _____

Medical Director's Name: _____

To be appointed by the County of San Diego for placement on an Involuntary Electroconvulsive Treatment Review Committee, please complete the signed attestation below by the requesting physician and Medical Director and email the complete form along with the physician's CVs to the BHS ECT Lead at BHSContactUs.HHSA@sdcounty.ca.gov

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Attestation

I, the above referenced Physician requesting appointment, attest to the following:

Please initial below	
	I have reviewed and will maintain compliance with California Welfare and Institutions Code (WIC) Section 5326.7.

_____ _____

Physician Signature Date

I, the above referenced Medical Director, attest to the following:

Please initial below	
	Involuntary ECT policies and procedures at the program/facility referenced above maintains compliance with California Welfare and Institutions Code (WIC) Section 5326.7.
	The physician requesting appointment is a board-certified or board-eligible psychiatrist or neurologist.
	If there is any change to the licensure status, professional privileges, or any restriction that may affect the qualifications of this physician appointment, I agree to immediately notify the BHS ECT Lead at BHSContactUs.HHSA@sdcounty.ca.gov .

_____ _____

Medical Director's Signature Date