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**APPLICATION TO FIRST TIER TRIBUNAL**

Please tick the relevant application type			
Application by or on behalf of a Non Restricted Patient (including Community Treatment Orders)		<b>Hospital Referral</b>	
Application by or on behalf of a Non Restricted Patient detained on Section 2		<b>Ministry of Justice Referral</b>	
Application by the Nearest Relative		<b>Ministry of Justice Referral following Recall to Hospital</b>	
Application by or on behalf of a Restricted Patient			

Please complete all information requested in this part of the application form	
<b>Patients Name</b>	
<b>Date of Birth</b>	
<b>Section</b>	
<b>Detention Date</b>	
<b>Hospital</b> (where patient is detained)	
For patients in the community please enter <b>Name and Address of Community Supervisor or Responsible Authority</b>	

Nearest Relative Details if known	
<b>Name</b>	
<b>Address</b>	
<b>Relationship to Patient</b>	
Solicitors Details if known	
<b>Represented:</b>	
<b>Name of Solicitor</b>	
<b>Solicitors Firm</b>	
<b>Telephone Number</b>	
<b>Email Address</b>	
<b>Un-represented:</b> *Delete as appropriate	- I intend to appoint a solicitor myself* - I would like a solicitor to be appointed on my behalf* - I do not wish to appoint a solicitor as I intend to represent myself at the hearing*

Does the patient require an Interpreter/have other special requirements?	
<b>If an interpreter is required please enter the language and dialect required?</b>	
<b>If applicable, please tell us of other special requirements for the Tribunal hearing</b>	

<b>Signature</b>		<b>Print Name</b>	
<b>Date</b>			

**Completed forms should be sent to**

**The Tribunal Service  
Mental Health  
PO Box 8793  
5<sup>th</sup> Floor  
Leicester  
LE1 8BN**