

**FORM 19**  
**MENTAL HEALTH ACT**  
[ Section 36, R.S.B.C. 1996, c. 288 ]

## CERTIFICATE OF DISCHARGE

This is to certify that \_\_\_\_\_ ,  
*first and last name of patient (please print)*

was discharged from \_\_\_\_\_  
*name of designated facility*

on \_\_\_\_\_ .  
*date (dd / mm / yyyy)*

\_\_\_\_\_  
*director's signature*

\_\_\_\_\_  
*date (dd / mm / yyyy)*

\_\_\_\_\_  
*name of director (please print)*