**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)*