

POLICY/PROCEDURE/PLAN REVIEW FORM

This policy/procedure/plan should be reviewed and returned to the Legal Services Department no later than **11/28/2011**. Please consult with all subject matter experts involved with this policy. All forms should go through the forms committee.

Protocol: 03-510 Seclusion & Restraints

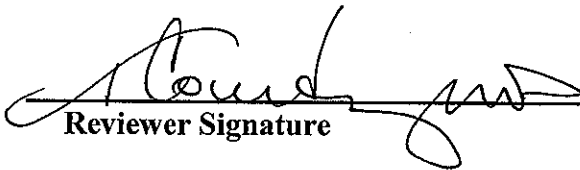
Reviewer: Theresa Courtney, Chief Medical Officer

SECTION I: MANAGEMENT REVIEW

I have reviewed the above named policy/procedure/plan and

- NO REVISION is necessary New Procedure is necessary
- REVISION is necessary New Plan is necessary
- DELETE Policy/Procedure/Plan

Updated forms relating to this policy/procedure/plan are attached.



Reviewer Signature

12/2/11

Date

SECTION II: LEGAL SERVICES REVIEW

I have reviewed the above named policy/procedure/plan and

- I agree that NO REVISION is necessary
- I approve Reviewer's ^{new protocol} ~~REVISION~~ which is attached
- Further REVISION has been made and is attached



Director of Legal & Special Services

12/2/11

Date

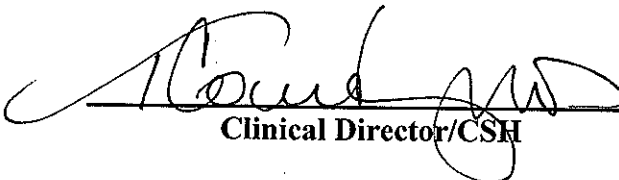
APPROVED BY:



Regional Hospital Administrator

12/2/11

Date



Clinical Director/CSH

12/2/11

Date