

WHISTLEBLOWER ABUSE CASE FORM:

As a doctor, nurse, mental health worker, other caregiver, witness or victim, have you ever been sickened or upset by the physical or mental abuse or harm dealt to patients in a psychiatric facility or under psychiatric care?

Perhaps you have tried to change the things you see are wrong and have been ignored, ridiculed or threatened by the psychiatric establishment. If so, you are not wrong in your efforts, and you are not alone.

It is vital that criminal psychiatric abuse is reported to the proper law enforcement agencies so action can be taken. This is where you can help, by filling out and submitting the form below.

After printing this form, fill it out as completely as possible, then mail it to:

CCHR International
6616 Sunset Blvd.
Los Angeles, CA 90028

Please fill out the following:

Your information:

Name: _____

Address: _____

City: _____

State/Province: _____

Zip/Postal Code: _____

Country: _____

Phone: _____

Email Address: _____

Birth Date: _____

WHEN DID THE ABUSE YOU WISH TO REPORT OCCUR?

WHAT WAS THE ABUSE YOU WISH TO REPORT?

WHAT WAS THE DIAGNOSIS GIVEN?

WAS THIS GIVEN AFTER A THOROUGH MEDICAL EXAMINATION FOR UNDERLYING PHYSICAL PROBLEMS WHICH COULD LOOK LIKE "MENTAL ILLNESS"?

YES
NO

WAS THERE HEALTH INSURANCE INVOLVED?

DID IT SEEM THE DIAGNOSIS WAS BASED ON WHAT INSURANCE COVERAGE WAS HELD?

WAS LENGTH OF HOSPITALIZATION INCREASED OR DECREASED BASED ON INSURANCE HELD?

WAS INFORMED, WRITTEN CONSENT GIVEN BEFORE ANY TREATMENT WAS ADMINISTERED?

WAS THE PERSON GIVEN A COPY OF HIS/HER RIGHTS, INCLUDING THE RIGHT TO SEE AN ATTORNEY, WHEN ADMITTED OR PRIOR TO ANY HEARING TO DETERMINE INVOLUNTARY PLACEMENT OR COMMITMENT TO A PSYCHIATRIC FACILITY?

WHO WAS THE TREATING DOCTOR ON THE CASE? PLEASE WRITE IN FULL: NAME AND WHAT KIND OF A DOCTOR THEY ARE: I.E. PSYCHIATRIST, PSYCHOLOGIST, ETC.

WHAT WAS THE LAST KNOWN ADDRESS AND PHONE NUMBER OF THE PRACTICE OF THIS PSYCHIATRIST, PSYCHOLOGIST, ETC.?

WHAT ARE THE NAMES OF ANY OTHER STAFF OR DOCTORS THAT YOU FEEL WERE INVOLVED IN THE ABUSES? (Please state what their position [job] was.)

WHAT IS THE NAME OF THE HOSPITAL/FACILITY THAT THIS OCCURRED IN? IF MORE THAN ONE FACILITY, PLEASE INDICATE. INCLUDE THE ADDRESS AND PHONE NUMBER FOR EACH FACILITY IF KNOWN:

In addition, are you interested in the following:

1. Doing media interviews on this case to alert the public to these issues?

Yes
No

2. Assisting in obtaining legislation in your state on issues that address the type of abuses in this case?

Yes
No

3. Writing letters to congressmen on these abuses?

Yes
No

Thank you again for filling out this interview form. Someone from our office will be getting back to you to assist with the next steps to take on this case once this information has been reviewed and it has been determined what we can best do to help expose and correct what has been done.

Please mail the completed form to:

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