FOID Request for Relief
Forensic Mental Health Assessment
Pursuant to: 20 Ill. Admin. Code 3500.200

Instructions: Please provide a copy of this form to the examiner prior to your evaluation and ask that it be returned directly to: FCRB.Appeals@illinois.gov
If you are unable to submit forms electronically, please contact the FOID Card Review Board at (217) 524-1762.

The forensic mental health assessment:

1. ***Must be*** completed by an Illinois Licensed Psychiatrist or Clinical Psychologist, who is not affiliated with the patient's employer.
2. ***Must include***:
   a. a forensic mental health assessment of the patient's ability to possess firearms, including but not limited to consideration of the circumstances resulting in the firearms disability, as well as current and prior:
      (1) psychiatric hospitalization, referrals, and treatment;
      (2) substance or alcohol abuse, dependence, and treatment;
      (3) psychiatric diagnoses; and
      (4) psychotropic medications, their dosage, and risks associated.
   b. the treatment provider's professional opinion as to whether the patient is likely to act in a manner dangerous to public safety, including but not limited to whether the patient:
      (1) is a serious threat of physical violence against a reasonably identifiable victim;
      (2) poses a clear and imminent risk of harm or serious physical injury to himself or another person;
      (3) demonstrates threatening physical or verbal behavior, such as violent, suicidal, or assaultive threats, actions, or other behavior; and
      (4) is mentally fit to acquire, possess and use firearms.

Name of Patient: _____ *Last name, First name, Middle Initial*	Date of Birth: _____ *Month/Day/Year*
Address: _____ *Street or Mailing address; City, State, and Zip Code*	

By affixing my signature below, I affirm:

- I am not affiliated with the patient's employer;
- I have reviewed records from all prior psychiatric hospitalizations and treatment;
- The forensic mental health assessment was conducted consistent with nationally accepted guidelines for forensic psychology; and
- I understand this form and any report or letter affixed hereto must be sent by me or my office directly to the FOID Card Review Board and will be relied upon by the Board in determining whether to grant relief to the patient's firearms prohibitor.

Printed Name:	Signature:	Date of Evaluation:
Title:	Telephone #:	Fax #:

Email:	Professional License #:
Printed Address: *Street or Mailing Address* _____ *City, State, Zip Code*	For additional information regarding the FOID Card Review Board and the Request for Relief process, please visit our website at https://isp.illinois.gov/FOIDCardReviewBoard