**Form 1**

**Consent to Voluntary Hospitalization**

Date (mm/dd/yyyy): / /

To Director of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital

Hospitalized Patient Name:

Date of Birth (mm/dd/yyyy): / /

Address:

I hereby state that I have read the Notice Regarding Voluntary Hospitalization (including notification of matters at the time of admission) and agree to be admitted to your hospital in accordance with Article 21 Section 1 of the Act on Mental Health and Welfare for the Mentally Disabled.