RE: _____

CAUSE # _____

DOB: _____

AGREEMENT OF COMMUNITY OUTPATIENT CARE PROVIDER

I have reviewed the conditions provided to me in reference to the above cause number, and agree to monitor this less restrictive alternative order consistent with the terms of RCW 71.05.585

Signed at _____, Washington, this ____ day of_____, 20____.

_____
Agency

_____
Agency Representative
printed name

_____
Agency Representative
Signature