
CHEBOYGAN COUNTY DRUG COURT

REFERRAL FORM

Circuit Court, 870 S. Main, P.O. Box 70, Cheboygan, MI 49721

Phone (231) 627-8818

Fax (231) 627-8419

******* TO BE COMPLETED BY DEFENSE ATTORNEY *******

Defendant's Name: _____ Case No.: _____

Address: _____

Telephone : _____ DOB: _____ Sex: _____ DL#: _____

I wish to participate in the Drug Court Program

Defendant's signature

Date: _____

Defense Attorney signature

Date: _____

******* TO BE COMPLETED BY PROSECUTOR *******

Decline entry into Drug Court Program

Approve entry into Drug Court Program

Current charge(s): _____

Plea Agreement: _____

Comments: _____

PLEA MUST BE ENTERED BY: _____

Prosecuting Attorney signature

Date: _____