

EMERGENCY MEDICAL PREHOSPITAL CARE APPLICATION FOR
DO-NOT-RESUSCITATE ORDERS-RELIGIOUS
SAGINAW VALLEY MEDICAL CONTROL AUTHORITY

Please Print or Type

Patient Name: _____

Date of Birth: _____ Age: _____ Sex: _____ Phone: _____ County: _____

Address: _____ City: _____ Zip Code: _____

Personal Physician: _____ Physician Phone: _____

Preferred Hospital: _____

“DO-NOT-RESUSCITATE ORDER”

I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me.

This order is effective until it is revoked by me.

Being of sound mind, I voluntarily execute this order, and I understand its full import.

(Declarant's Signature)

Date

(Type or Print Declarant's Full Name)

Date

(Signature of Person Who Signed for Declarant, if Applicable)

Date

(Type or Print Full Name & Relationship to Declarant)

Date

EMS OFFICE USE ONLY
Date of Request: _____
Effective Date: _____
SVMCA Number: _____
_____ Signature/Seal of Medical Director

