EMERGENCY MEDICAL PREHOSPITAL CARE APPLICATION FOR
DO-NOT-RESUSCITATE ORDERS-MEDICAL
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: _____

*Diagnosis: _____ Preferred Hospital: _____
*(Although a diagnosis is not required by statute, we would prefer this for clinical information)

"DO-NOT-RESUSCITATE ORDER"

I have discussed my health status with my personal physician, _____.
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.

_____ _____
(Declarent's Signature) Date

_____ _____
(Type or Print Declarent's Full Name) Date

_____ _____
(Signature of Person Who Signed for Declarent, if Applicable) Date

_____ _____
(Type or Print Full Name & Relationship to Declarent) Date

_____ _____
(Physician's Signature) Date

_____ _____
(Type or Print Physician's Full Name Date

EMS OFFICE USE ONLY

Date of Request: _____

Effective Date: _____

SVMCA Number:

_____

_____
Signature/Seal of Medical Director

Over

ATTESTATION OF WITNESSES
(Two Witnesses Required)

The individual who has executed this order appears to be of sound mind, and under no duress, fraud or undue influence. Upon executing this order, the individual has (has not) received an identification bracelet.

(1) _____ _____
(Witness Signature) (Date)

_____ _____
(Type or Print Witness's Name) (Date)

(2) _____ _____
(Witness Signature) (Date)

_____ _____
(Type or Print Witness's Name) (Date)

This form was prepared pursuant to, and is in compliance with the "Michigan DO-NOT-RESUSCITATE Procedure Act".

Please return this completed form to the:

SVMCA OFFICE OF THE MEDICAL DIRECTOR
1000 Houghton Avenue
Saginaw, Michigan 48602
Attn: DNR Program

Over