

**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.

_____	_____
(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
_____	_____
(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

