EMERGENCY MEDICAL PREHOSPITAL CARE RESCIND FORM
DO-NOT-RESUSCITATE ORDERS
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 RESCIND ORDER"

I request that in the event my heart and breathing should stop, every attempt will be made 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.
This order specifically revokes any prior prehospital "DNR" orders or forms I may have completed and filed.

______________________________ ____________
(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)

EMS OFFICE USE ONLY

Date of Request: ____________

Effective Date: ____________

SVMCA Number:

____

____
Signature/Seal of Medical Director

In the presence of ____________________, on ____________, 20____, in ____________ County, Michigan.
Notary Signature: ______________________ ________ Printed Name: ______________________
County of Commission: ______________________ Commission Expiration Date: ______________
Notary Public

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 will return the purple identification bracelet to the office of the Saginaw Valley Medical Control Authority.

(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:

OFFICE OF EMERGENCY MEDICAL SERVICES
1000 Houghton Avenue
Saginaw, Michigan 48602
Attn: Cheryl Such

Over