

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)

\_\_\_\_\_

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

