PREHOSPITAL MEDICAL CARE DIRECTIVE

(side one)

IN THE EVENT OF CARDIAC OR RESPIRATORY ARREST, I REFUSE ANY RESUSCITATION MEASURES INCLUDING CARDIAC COMPRESSION, ENDOTRACHEAL INTUBATION AND OTHER ADVANCED AIRWAY MANAGEMENT, ARTIFICIAL VENTILATION, DEFIBRILLATION, ADMINISTRATION OF ADVANCED CARDIAC LIFE SUPPORT DRUGS AND RELATED EMERGENCY MEDICAL PROCEDURES.

Patient: _____ Date: _____

(Signature or mark)

Attach recent photograph here or provide all of the following information below:

Date of Birth _____

Sex _____ Race _____

Eye Color _____

Hair Color _____

PHOTO

Hospice Program (if any)_____

Name and telephone number of patient's physician_____

_____

(side two)

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above (on reverse side).

_____ Date_____
(Licensed health care provider)

I was present when this was signed (or marked). The patient then appeared to be of sound mind and free from duress.

_____ Date_____
(Witness)