

PREHOSPITAL MEDICAL CARE DIRECTIVE

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's Printed Name: _____

Patient's Signature: _____ Date: _____

***If I am unable to communicate my wishes, and I have designated a Health Care Power of Attorney, my elected Health Care agent shall sign:**

Health Care Power of Attorney Printed Name: _____

Health Care Power of Attorney Signature: _____

PROVIDE THE FOLLOWING INFORMATION OR ATTACH A RECENT PHOTO:

Date of Birth _____

Sex _____

Race _____

Eye Color _____

Hair Color _____



INFORMATION ABOUT MY DOCTOR AND HOSPICE (if I am in Hospice):

Physician: Ryan Wood Telephone: 623.248.6636

Hospice Program, if applicable (name): Encore Hospice LLC

SIGNATURE OF DOCTOR OR OTHER HEALTH CARE PROVIDER

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.

Signature of a Licensed Health Care Provider: _____

Date: _____

SIGNATURE OF WITNESS OR NOTARY (NOT BOTH)

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

Witness Signature: _____ Date: _____

NOTORIAL JURAT:

STATE OF ARIZONA) ss

COUNTY OF _____)

Patient's Name/Health Care Power of Attorney Name

Subscribed and sworn (or affirmed) before me this _____ day of _____, 20 _____

Notary Public Signature: _____ My Commission Expires: _____