Important!

Important!
In order to be legally valid this form MUST be printed on yellow paper prior to being completed. EMS and medical personnel are only required to honor the form if it is printed on yellow paper.

This box will not show up when the form is printed.



State of Florida DO NOT RESUSCITATE ORDER

(please use ink)

Patient's Full Legal Name:	Date:
(Print or Typ	e Name)
Based upon informed consent, I, the undersigned	STATEMENT In hereby direct that CPR be withheld or withdrawn. In the check applicable box):
□ Surrogate □ Proxy (both as defined in Chapter 765, F.S.) □ Court appointed guardian □ Durable power of attorney (pursuant to Chapter 709, F.S.)	
(Applicable Signature)	(Print or Type Name)
PHYSICIAN'S I, the undersigned, a physician licensed pursuant to Chepatient named above. I hereby direct the withholding of (artificial ventilation, cardiac compression, endotrached in the event of the patient's cardiac or respiratory arres	r withdrawing of cardiopulmonary resuscitation al intubation and defibrillation) from the patient
(Signature of Physician) (Date)	Telephone Number (Emergency)
(Print or Type Name)	(Physician's Medical License Number)
DH Form 1896, Revised December 2002	
PHYSICIAN'S STATEMENT I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the	State of Florida HEALTH DO NOT RESUSCITATE ORDER Patient's Full Legal Name (Print or Type) (Date)
event of the patient's cardiac or respiratory arrest. (Signature of Physician) (Date) Telephone Number (Emergency)	PATIENT'S STATEMENT Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn. (If not signed by patient, check applicable box): □ Surrogate □ Proxy (both as defined in Chapter 765, F.S.) □ Court appointed guardian □ Durable power of attorney (pursuant to Chapter 709, F.S.)
(Print or Type Name) (Physician's Medical License Number)	

(Applicable Signature)

(Print or Type Name)