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.

FLORIDA DEPARTMENT OF HEALTH

State of Florida
DO NOT RESUSCITATE ORDER

(please use ink)

Patient's Full Legal Name: _____Date:_____
(Print or Type Name)

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Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn.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
❑ Court appointed guardian
❑ Proxy (both as defined in Chapter 765, F.S.)
❑ Durable power of attorney (pursuant to Chapter 709, F.S.)

_____
(Applicable Signature) (Print or Type Name)

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 event of the patient's cardiac or respiratory arrest.

_____
(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 event of the patient's cardiac or respiratory arrest.

_____
(Signature of Physician) (Date) Telephone Number (Emergency)

_____
(Print or Type Name) (Physician's Medical License Number)

DH Form 1896,Revised December 2002

FLORIDA DEPARTMENT OF HEALTH

State of Florida
DO NOT RESUSCITATE ORDER

_____
Patient's Full Legal Name (Print or Type) (Date)

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Based upon informed consent, I, the undersigned,hereby direct that CPR be withheld or withdrawn.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.)

_____
(Applicable Signature) (Print or Type Name)