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	DO-NOT-RESUSCITATE (DNR) DIRECTIVE	
	This section is optional. If you do not want ambulance crews to revive you if your heart or breathing stops, you <b>and</b> your physician ( <b>or</b> nurse practitioner <b>or</b> physician assistant) must complete and sign this form.	
回	FOR PATIENT TO COMPLETE after consultation with his or her health care provider:	
005	In the event that my heart or breathing stops and I am unable to speak for myself, I,	
	I understand that I may change my mind at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry, such as MedicAlert. I will also tell my physician (or nurse practitioner or physician assistant) and other caregivers if I change my mind.	
90	I understand that this form is not valid until my physician ( <b>or</b> nurse practitioner <b>or</b> physician assistant) <b>and</b> I have signed it.	9 9
	I understand that in a hospital, nursing home, hospice or home health setting, federal law requires that my physician must include a specific DNR order in my medical record or plan of care, even if we have both signed this form.	
	No expiration date OR Expires on	
	Patient Signature Date Signed	
	FOR PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER TO COMPLETE:	
	By my signature I affirm that:	
	(i) After meeting with this patient and discussing this decision, I am satisfied that the patient understands	
	the potential risks, burdens and benefits of refusing resuscitative interventions in light of the patient's medical condition; and (ii) I believe that the patient has made a voluntary informed decision about	
	resuscitation and I agree to comply with that decision. I will tell any health care providers providing care under my authority to comply with this decision.	
9	Signature and license level (MD, DO, PA or NP)  Date Signed	
	Printed Name Telephone Number	
	THIS FORM IS ENDORSED BY MAINE EMERGENCY MEDICAL SERVICES	
	Revised February 2008	