



**STATE OF INDIANA  
OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER**

State Form 49559 (R / 9-11)



**This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.**

**OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION**

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below.

**I declare:**

My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this Out of Hospital Do Not Resuscitate Declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

**I understand the full import of this declaration**

Signature of declarant

Printed name of declarant

City and state of residence

The declarant is personally known to me, and I believe the declarant to be of sound mind. I did not sign the declarant's signature above, for, or at the direction of, the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Signature of witness

Printed name

Date (month, day, year)

Signature of witness

Printed name

Date (month, day, year)

**OUT OF HOSPITAL DO NOT RESUSCITATE ORDER**

I, \_\_\_\_\_, the attending physician of \_\_\_\_\_, have certified the declarant as a qualified person to make an Out Of Hospital Do Not Resuscitate Declaration, and I order health care providers having actual notice of this Out Of Hospital Do Not Resuscitate Declaration and Order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the Out Of Hospital Do Not Resuscitate Declaration is revoked.

Signature of attending physician

Printed name of attending physician

Medical license number

Date (month, day, year)