



**DO-NOT-RESUSCITATE IDENTIFICATION  
APPLICATION - MINOR**

**Patient Information**

(Please Print or Type)

Name \_\_\_\_\_ Gender  M  F  
SS# \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

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**Parent or Legal Guardian's Statement**

**I, the parent or legal guardian of the above named minor, do not wish that life-resuscitating treatment be undertaken in the event of a cardiac or respiratory arrest of the above named minor. Therefore, I direct Emergency Medical Services personnel to withhold life-resuscitating treatment in the event of a cardiac or respiratory arrest of the above named minor.**

Parent or legal guardian's name (print): \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Parent or legal guardian's signature: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**Attending Physician's Statement (Must be a Nevada MD, DO, or APRN)**

As required by Nevada Revised Statute (NRS) 450B.525, I certify I am the above named patient's physician who has primary responsibility for the treatment and care of said patient, the patient suffers from a terminal condition, and the patient has been issued a Do-Not-Resuscitate Order pursuant to NRS 450B.510.

Attending physician's name (print): \_\_\_\_\_ Phone: \_\_\_\_\_  
Attending physician's signature: \_\_\_\_\_ License number: \_\_\_\_\_

Office Use Only:

Received: \_\_\_\_\_ Issued: \_\_\_\_\_ By: \_\_\_\_\_ DNR ID # \_\_\_\_\_

**APPLICANT INSTRUCTIONS**

1. Provide the information required in the **“Patient Information”** section of the application.
2. Sign and date the **“Parent or Legal Guardian Statement”** on the application.
3. Have your attending physician complete and sign the **“Attending Physician’s Statement”** on the application.
4. Mail the completed application to:  
  
Southern Nevada Health District  
Office of EMS & Trauma System  
P.O. Box 3902  
Las Vegas, NV. 89127

In accordance with NRS 450B.525, a parent or legal guardian of a minor may apply to the health authority for a do-not-resuscitate identification on behalf of a minor if the minor has been determined by his attending physician to be in a terminal condition and has been issued a do-not-resuscitate order pursuant to NRS 450B.510.

An application submitted must include, without limitation; certification by the minor’s attending physician that the minor suffers from a terminal condition and has been issued a do-not-resuscitate order pursuant to NRS 450B.510; a statement that the parent or legal guardian of the minor does not wish that life-resuscitating treatment be undertaken in the event of a cardiac or respiratory arrest; the name of the minor; the name, signature, and telephone number of the minor’s attending physician; and the name, signature, and telephone number of the minor’s parent or legal guardian.

The parent or legal guardian of the minor may revoke the authorization to withhold life-resuscitating treatment by removing or destroying or requesting the removal or destruction of the identification or otherwise indicating to a person that he wishes to have the identification removed or destroyed.

Do-Not-Resuscitate Identification will be a card and document issued by the Southern Nevada Health District signifying the person is a qualified patient who wishes not to be resuscitated in the event of cardiac or respiratory arrest. NRS 450B.410.

Life-resuscitating treatment means cardiopulmonary resuscitation (CPR) or any of its components including chest compressions, defibrillation, cardioversion, assisted ventilation, airway intubation and administration of cardiac medications.

For additional information please call:  
Southern Nevada Health District  
Office of EMS & Trauma System  
(702) 759-1050



**DO-NOT-RESUSCITATE**

**IDENTIFICATION**

**APPLICATION**

**MINOR (<18 YEARS OF AGE)**

Southern Nevada Health District  
Office of EMS & Trauma System  
P.O. Box 3902  
Las Vegas, NV. 89127

**ATTENDING PHYSICIAN’S INSTRUCTIONS**

Complete the **“Attending Physician’s Statement”** by:

1. Providing your name, telephone number, license number, and
2. Signing the **“Attending Physician’s Statement”** where indicated.