

Morris Hospital EMS System
MULTIPLE PATIENT RELEASE FORM

Agency: _____ Date: ____/____/____ Type of Call: _____

Location of Call: _____ Brief Description of Call: _____

of Pt's: ____ # of Pt's Transported: ____ # of Pt's Refusing: ____ Unit #'s on Scene: ____/____/____

State Run Form #: _____ Agency Incident #: _____ Resc. Hosp. Log #: _____

Call Time: ____:____:____ On Scene: ____:____:____ At Pt's Side: ____:____:____ In Service: ____:____:____

RELEASE FROM MEDICAL RESPONSIBILITY

I/we hereby refuse the emergency medical services, assessment, treatment and/or transportation to a medical facility offered and advised by the above name service provider. I/we hereby release Morris Hospital EMS System, the provider service, their personnel and employees, Morris Hospital and Healthcare Centers and its emergency nursing personnel and physicians of any further responsibility and acknowledge that I have been advised by the ambulance personnel that I should have emergency first-aid treatment, which I/we are refusing, and acknowledged by my signature below. I understand my refusal may jeopardize the health of the patient, and I/we should consult a private physician regarding medical treatment. I hereby release the above named parties from any and all claims of liability in connection with this incident and my signed refusal.

Print Name	Address	City/State/Zip
_____	____/____/____	_____
Signature	Date of Birth	Age <u>Male / Female</u> Relationship
_____	_____	_____

Print Name	Address	City/State/Zip
_____	____/____/____	_____
Signature	Date of Birth	Age <u>Male / Female</u> Relationship
_____	_____	_____

Print Name	Address	City/State/Zip
_____	____/____/____	_____
Signature	Date of Birth	Age <u>Male / Female</u> Relationship
_____	_____	_____

Print Name _____ Address _____ City/State/Zip _____
_____/_____/_____
Signature _____ Date of Birth _____ Age _____ Male / Female _____
Relationship _____

Print Name _____ Address _____ City/State/Zip _____
_____/_____/_____
Signature _____ Date of Birth _____ Age _____ Male / Female _____
Relationship _____

Print Name _____ Address _____ City/State/Zip _____
_____/_____/_____
Signature _____ Date of Birth _____ Age _____ Male / Female _____
Relationship _____

Print Name _____ Address _____ City/State/Zip _____
_____/_____/_____
Signature _____ Date of Birth _____ Age _____ Male / Female _____
Relationship _____

Print Name _____ Address _____ City/State/Zip _____
_____/_____/_____
Signature _____ Date of Birth _____ Age _____ Male / Female _____
Relationship _____

AMBULANCE CREW MEMBERS

1. _____ SYSTEM # _____
2. _____ SYSTEM # _____
3. _____ SYSTEM # _____
4. _____ SYSTEM # _____
5. _____ SYSTEM # _____
6. _____ SYSTEM # _____