

DOC # 0701294
05/16/2007 01:52 PM Deputy: PK
OFFICIAL RECORD
Requested By:
BONNIE TIJERINA

Assessor's Parcel Number: _____

Recording Requested By: _____

Name: Bonnie Tijerina

Address: P.O. Box 1774 - 1313 Sanden Lane

City/State/Zip Minden Nevada 89423

Real Property Transfer Tax: \$ _____

Douglas County - NV
Werner Christen - Recorder

Page: 1 of 2 Fee: 15.00
BK-0507 PG- 5802 RPTT: 0.00



Application

(Title of Document)

This page added to provide additional information required by NRS 111.312 Sections 1-2. (Additional recording fee applies)

This cover page must be typed or legibly hand printed.

STATE OF NEVADA
DO-NOT-RESUSCITATE IDENTIFICATION
APPLICATION

Applicant Information

(Please print or Type)

Name Genevieve Rucker Gender M F Date of Birth 12/20/16
Address 1313 Sanden City Minden State NV ZIP 89423

Patient's Statement

I, the above named patient, **do not wish to receive life-resuscitating treatment in the event of a cardiac or respiratory arrest.** Therefore I, or my agent with a durable power of attorney for healthcare, direct Emergency Medical Services personnel to withhold life-resuscitating treatment.

I verify that I have notified each member of my immediate family whose whereabouts are known to me, and/or my legal guardian or caretaker of my decision to apply for Do-Not-Resuscitate Identification.

Patient's signature X Genevieve Rucker Date 5/15/07
or

Signature of patient's agent Bonnie Tigerina POA Date 5/10/07

Printed name of patient's agent Bonnie Tigerina

Attending Physician's Statement

As required by NRS 450B.520(2), I certify the above named patient is under my care and suffers from a terminal condition. I also certify that the patient:

Check 1, 2A or 2B if the patient is applying for do-not-resuscitate identification. If application is being made on behalf of the patient by the attending physician check item 3.

1. Is capable of making an informed decision; or
2. When he was capable of making an informed decision, executed:
 - A. A written directive that life-resuscitating treatment be withheld under certain circumstances; or -
 - B. A durable power of attorney for health care pursuant to NRS 449.800 to 449.860, inclusive.
3. With the written approval of the above named patient, I have issued a do-not-resuscitate (DNR) order for the patient. Grounds for the DNR order have been documented in the patient's medical record.

Attending physician's name DeLacy McFarlane Phone number (775) 782-0055

Attending physician's signature [Signature]

Office Use Only

Received _____ Issued _____ By _____ DNR ID # _____

