CITY OF BELLEVILLE FIRE DEPARTMENT

Refusal of Service	
I have been advised that I should have treatment and that treatment is available immediately. I refuse such treatment and transportation to Hospital having been informed of the risks involved **I Assume full responsibility arising out of such refusal**	
Patient/Substitute Decision Maker (Print Name and Address)	
NAME:	
ADDRESS:	
TELEPHONE NUMBER:	
RELATIONSHIP TO PATIENT	**SIGNATURE OF PATIENT OR SUBSTITUTE DECISION MAKER**
TIME:	SIGNATURE OF FIRST WITNESS
TIME:	SIGNATURE OF SECOND WITNESS
I have advised this patient or the party responsible (substitute decision maker) for the above noted action to the patient's health that are involved.	
TIME AND DATE:	
SIGNATURE:	
I was witness to the above mentioned being given	
TIME AND DATE:	
SIGNATURE:	

FORM: S.O.G. #2001