

Patient Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

PARAMEDIC and EMT  
RELEASE FROM MEDICAL RESPONSIBILITY

I fully understand that only field medical treatment has been rendered to me and that I have been advised to consult an Emergency Room Physician or my Private Physician as soon as possible for further medical treatment. I release Community Ambulance Services, Inc. and its employees from any further responsibility for my refusal to be transported by ambulance at their advice for further medical treatment.

Patient/Parent/Guardian Signature: \_\_\_\_\_

Paramedic/EMT Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness Name (Print): \_\_\_\_\_

Witness Signature: \_\_\_\_\_