On-scene Physician Release Form

Agency Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Run # \_\_\_\_\_\_\_\_\_\_\_\_\_

**Warning: The signing of this document constitutes the assumption of legal liability by the signer for the care and treatment of the patient named below.**

The physician whose signature appears below, by subscribing this instrument acknowledges that:

1. He/she is aware that the ambulance or agency providers, named above, called to attend the below named patient, is operating under the coordination of the Bonner County Emergency Medical Services System.
2. That the BCEMS System supplies coordination for Basic and Advanced Life Support Systems in this geographic area.
3. That there is available to the attending EMS providers named above, a communications system capable of eliciting advice and instruction for the care and treatment of this patient by trained physicians under a system of guidelines and procedures subscribed to by physicians in the geographic area served by the EMS System.
4. That the undersigned physician assumes full responsibility for the care and treatment of the patient named below, and by his or her signature, agrees to hereby forever release and discharge EMS System, its agents, servants or employees and the attending ambulance EMS providers and its/ their agents, servants or employees from any cause of action whatsoever, including but not limited to, any action ever as a defendant in a lawsuit brought by the patient or his or her heirs, executors, administrators or assigns against said BCEMS System and or the ambulance EMS providers named above, by reason of the care and treatment to said patient under the orders of said undersigned physician.

**Warning: This is an assumption of legal responsibility for care of this patient and an indemnification to and release of BCEMS and the attending agency.**

In Winess wehereof,

I have hereunto set my hand and seal this \_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_.

Physician signature

Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_