

DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE
SELF PRESERVATION STATEMENT

Name of ARCH _____

I, _____ certify that

(Print physician's name)

(Resident's name)

is is not ambulatory (*).

He/she is is not capable of following directions and taking appropriate action for self-preservation under emergency conditions.

Physician / APRN signature

Date

Print or type Physician / APRN name

(*) "Ambulatory" means able to walk without human assistance.

HAR, Title 11, Chapter 100.1, mandates that each resident of a Type I ARCH must be certified by a physician that the resident is ambulatory and capable of following directions and taking appropriate action for self-preservation under emergency conditions [refer to section 11-100.1-23(g)(3)(l)].