

DEPARTMENT OF HEALTH  
OFFICE OF HEALTH CARE ASSURANCE  
**SELF PRESERVATION STATEMENT**

Name of ARCH

Care Homes by Hale Makua

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)(I)].