

NYS Department of Health Distribution Center
P.O. Box 343
Guilderland Center, NY 12084

Name: _____

Organization: _____

Street Address: _____

City/State/Zip: _____

Phone Number: _____

▲ Shipping Label: Please Type or Print Neatly ▲

TITLE	CODE NUMBER	QUANTITY
1. Medical Orders for Life-Sustaining Treatment (MOLST) form	DOH-5003	
2.		
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Date:		