# ADVANCE HEALTHCARE DIRECTIVE

## Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make healthcare decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

**Part 1** of this form is a power of attorney for health care. Part 1 lets you name another individual as an agent to make healthcare decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of [a residential long-term healthcare institution] at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all healthcare decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all healthcare decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

a.) consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
b.) select or discharge healthcare providers and institutions;
c.) approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
d.) direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

**Part 2** of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

**Part 3** of this form lets you express an intention to donate your bodily organs and tissues following your death.

**Part 4** of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. It is recommended but not required that you request two other individuals to sign as witnesses. Give a copy of the signed and completed form to your physician, to any other healthcare providers you may have, to any healthcare institution at which you are receiving care, and to any healthcare agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance healthcare directive or replace this form at any time.

## PART 1. POWER OF ATTORNEY FOR HEALTH CARE

1. **DESIGNATION OF AGENT**: I designate the following individual as my agent to make healthcare decisions for me:

   Agent's Name: _____
   Agent's Address: _____
   Cell Phone: (____) ____-_____

   OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a healthcare decision for me, I designate as my first alternate agent:

   1st Alternate Agent's Name: _____
   1st Alternate Agent's Address: _____
   1st Alternate Agent's Cell Phone: (____) ____-_____

   OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a healthcare decision for me, I designate as my second alternate agent:

   2nd Alternate Agent's Name: _____
   2nd Alternate Agent's Address: _____
   2nd Alternate Agent's Cell Phone: (____) ____-_____

2. **AGENT'S AUTHORITY**: My agent is authorized to make all healthcare decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

3. **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE**: My agent's authority becomes effective when my primary physician determines that I am unable to make my own healthcare decisions unless I mark the following box.

   If I mark this box ☐, my agent's authority to make healthcare decisions for me takes effect immediately.

4. **AGENT'S OBLIGATION**: My agent shall make healthcare decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make healthcare decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

5. **NOMINATION OF GUARDIAN**: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

## PART 2. INSTRUCTIONS FOR HEALTH CARE

If you are satisfied with allowing your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

6. **END-OF-LIFE DECISIONS**: I direct that my healthcare providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

   ☐ - (a) **Choice <u>NOT</u> To Prolong Life**. I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, OR

   ☐ - (b) **Choice <u>To</u> Prolong Life**. I want my life to be prolonged as long as possible within the limits of generally accepted healthcare standards.

7. **ARTIFICIAL NUTRITION AND HYDRATION**: Artificial nutrition and hydration must be provided, withheld, or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box ☐, artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

8. **RELIEF FROM PAIN**: Except as I state in the following space, I direct that treatment for the alleviation of pain or discomfort be provided at all times, even if it hastens my death:

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9. **OTHER WISHES**: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

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## **PART 3. DONATION OF ORGANS AT DEATH** (OPTIONAL)

10. **UPON MY DEATH**: (mark applicable box)

☐ - (a) I give any needed organs, tissues, or parts, OR

☐ - (b) I give the following organs, tissues, or parts only:
_____.

☐ - (c) My gift is for the following purposes (strike any of the following you do not want)
(i) Transplant
(ii) Therapy
(iii) Research
(iv) Education

## **PART 4. PRIMARY PHYSICIAN** (OPTIONAL)

11. **PHYSICIAN DESIGNATION**: I designate the following physician as my primary physician:

Physician's Name: _____
Agent's Address: _____
Cell Phone: (____) ____-_____

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Physician's Name: _____
Agent's Address: _____
Cell Phone: (____) ____-_____

12. **EFFECT OF COPY**: A copy of this form has the same effect as the original.

13. **SIGNATURES**: Sign and date the form here:

Principal's Signature: _____ Date: _____
Print Name: _____
Address: _____

14. (Optional) SIGNATURES OF WITNESSES

**1ST WITNESS**

Witness's Signature: _____ Date: _____
Print Name: _____
Address: _____

**2ND WITNESS**

Witness's Signature: _____ Date: _____
Print Name: _____
Address: _____

15. (Optional) NOTARY ACKNOWLEDGMENT

State of _____
County of _____

On _____, 20____ before me, _____ (name and title of officer), personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that she/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of _____ that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature: _____ (Seal)
Print Name: _____