Wyoming Advance Health Care Directive Form for:

_____

(print your full name)

Please place the completed document on the front of your refrigerator or another location where an emergency responder might easily see it.

These materials have been prepared as a public service by AARP Wyoming and are for informational purposes only and should not be construed as legal advice or as official State of Wyoming documents.

Print your full name: _____

Today's date: _____ **Initial that you have completed the page:** _____

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

PLEASE NOTE: *Answering any of the following questions is optional, but the more information you provide on this form, the better your designated agent may act on your behalf. This form is not to be used to designate a financial power of attorney. It is for health care matters only. This form is in compliance with Wyoming State Statute 35-22-401 through 416.*

(1) Designation of agent: I designate the following person as my agent to make health care decisions for me:

_____
(name of person you choose as your agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone) (cell phone)

If I revoke my agent's authority, or if my agent is not willing, able or reasonably available to make a health-care decision for me, **I designate as my alternate agent:**

_____
(name of person you choose as your alternate agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone) (cell phone)

(2) Agent's authority: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care, except as I state here:

_____

_____

_____
(Add additional sheets if needed.)

(3) When agent's authority becomes effective: My agent's authority to make health care decisions for me takes effect at the following time (**check and initial only one (1) option**):

Check Initial

☐ _____ If I check the box and initial**,** my agent's authority to make health care decisions for me becomes effective only when my primary physician or, in his/her absence, my treating primary health care provider determines that I lack the capacity to make my own health care decisions; **OR**

☐ _____ If I check the box and initial**,** my agent's authority to make health care decisions for me becomes effective only when my primary physician (and **not** when any then treating health care provider of mine) determines that I lack the capacity to make my own health care decisions; **OR**

☐ _____ If I check the box and initial**,** my agent's authority to make health care decisions for me becomes effective as necessary immediately upon my execution of this Advance Health Care Directive Form.

(4) Agent's obligation: My agent shall make health care decisions for me in accordance with this power of attorney for health care using any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent that my wishes are unknown, my agent shall make health-care 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.

Print your full name: _____

Today's date: _____ **Initial that you have completed the page:** _____

PART 2: INSTRUCTIONS FOR HEALTH CARE

(5) End-of-Life decisions: I direct that those involved in my care provide, withhold or withdraw treatment in accordance with the choice I have checked and initialed below (check and initial only one option):

Check Initial

☐ _____ (a) **Choice to Prolong Life:** I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

OR

☐ _____ (b) **Choice Not 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;

(iii) The likely risks and burdens of treatment would outweigh the expected benefits.

(6) Artificial nutrition and hydration: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (5) unless I have checked and initialed **one** of the boxes below:

Check Initial

☐ _____ I **want** artificial nutrition regardless of my condition.

☐ _____ I **do NOT** want artificial nutrition regardless of my condition.

☐ _____ I **want** artificial hydration regardless of my condition.

☐ _____ I **do NOT** want artificial hydration regardless of my condition.

Print your full name: _____

Today's date: _____ **Initial that you have completed the page:** _____

(7) Relief from pain:

Check **Initial**

☐ _____ I **want** treatment for the alleviation of pain or discomfort at all times;

OR

☐ _____ I **do NOT** want treatment for the alleviation of pain or discomfort.

(8) Other wishes: (If you do not agree with the choices above, you may write your own or add to the instructions above. Examples may include: blood or blood products; chemotherapy; simple diagnostic tests; invasive diagnostic tests; minor surgery; major surgery; antibiotics; oxygen; wish to die at home if possible; etc.) I direct that:

_____

_____

_____

_____

PART 3: DONATION OF ORGANS AND TISSUES UPON DEATH

(9) Upon my death (check and initial applicable boxes):

Check **Initial**

☐ _____ (a) I have arranged to give my body to science.

☐ _____ (b) I have arranged through the Wyoming Donor Registry to give any needed organs and/or tissues (For enrollment information, call 1-888-868-4747 or visit WyomingDonorRegistry.org).

☐ _____ (c) **I do NOT** wish to donate my body, organs and/or tissues.

Print your full name: _____

Today's date: _____ **Initial that you have completed the page:** _____

PART 4: INFORMATION ABOUT MY HEALTH CARE PROVIDER

(10) The following physician is my primary physician:

_____
(name of physician)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

More information about my health care can be obtained through:

_____
(name of health care institution/hospice)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

(11) Effect of copy: A copy of this form has the same effect as the original.

SIGNATURE (Sign and date the form here):

_____
(print your name)

_____
(sign your name) (date)

_____
(address)

_____
(city) (state) (zip code)

SIGNATURES OF WITNESSES or NOTARY PUBLIC:

I declare under penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is known to me to be the principal, and that the principal signed or acknowledged this document in my presence.

Please Note: *Under Wyoming State Statute 35-22-403 (b), a witness may not be a treating health care provider, operator of a treating health care facility or an employee of a treating health care facility.*

First witness

_____ _____
(print witness' name) (address)

_____ _____
(signature of witness) (date)

Second witness

_____ _____
(print witness' name) (address)

_____ _____
(signature of witness) (date)

OR

Notary (in lieu of witnesses)

State of Wyoming

County of_____ } SS.

Subscribed and sworn to and acknowledged before me by_____,
the Principal, this _____ day of _____, _____.

My commission expires: _____.

_____
Notary Public's signature