



## Roger Rienman McBee

It is very important for you to discuss your medical treatment goals and wishes with your healthcare agent, your family, and your medical care providers. Keep in mind that advance medical directives are simply expressions of your medical treatment goals and preferences. There is no guarantee that your medical care providers will follow all of your wishes, but one thing is certain: **If your advance medical directives cannot be quickly located and retrieved in a time of need, then medical care providers, your family and friends will not be able to take your wishes into consideration when they make critical decisions regarding your treatment.**

### Part 1

#### Appointment of a Primary Healthcare Agent and Alternate Healthcare Agents

*IF THIS PART OF THE uADD™ IS LEFT BLANK, I AM DELIBERATELY DECLINING  
TO DESIGNATE A HEALTHCARE AGENT AND REQUESTING THAT  
THE DOCTORS ON DUTY MAKE DECISIONS BASED ON MY GUIDELINES.*

I am appointing the person or persons below as my healthcare agent and, if applicable, as my alternate healthcare agent(s), and I am granting to each of them the legal authority to make medical treatment decisions on my behalf and to consult with my physician and others. The power to make medical treatment decisions that I am granting to my healthcare agent(s) is expressly subject to, and limited by, the choices that I have expressed elsewhere in my uADD. If my medical treatment choices are not clear, I am authorizing and directing my healthcare agent to make decisions in my best interests and based on what is known of my wishes.

#### The person I choose as my Primary Healthcare Agent is:

*Dr. Allen Park (General Practitioner)*

*(454) 785-8887*

*kennedy.stephen3@gmail.com*

*[ACCEPTED to act as a healthcare agent on 7/22/2014, at 3:10 PM CST]*

If this healthcare agent is unable or unwilling to make medical treatment decisions for me, or if my spouse is designated as my primary healthcare agent and our marriage is annulled, or we are divorced or legally separated, **then my next choice for a healthcare agent is:**

#### First Alternate Healthcare Agent

*Sally Bobbins (Wife)*

*kennedy.stephen3+2@gmail.com*

*[ACCEPTED to act as a healthcare agent on 7/22/2014, at 3:15 PM CST]*

#### My Healthcare Agent's General Authority

Subject to my medical treatment choices expressed elsewhere in this uADD™ and applicable law that requires otherwise, *I grant to my healthcare agent the power to make all choices and medical treatment decisions for me.*



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### Part 2

### Expression of Healthcare Treatment Wishes and Desires

If I cannot express my own wishes for medical treatment, I would like the doctors treating me, as well as my healthcare agent if I have chosen one, to make decisions based as much as possible and appropriate on my instructions below. *If at some point in the future I am declared incompetent, I DO NOT want to be allowed to override these preferences. I want my doctors to follow the preferences I express in this document.*

#### My Advance Care Goals

If I am so sick or seriously injured that I cannot express my own medical treatment preferences, and if I am not expected to live without additional treatment for my illness, disease, condition or injury, then I want my medical care team to know that these are the things that are most important to me:

- 1. Being at peace my with God*
- 2. Being able to feed, bathe, and take care of myself*
- 3. Being free from pain*
- 4. Resolving conflicts*
- 5. Being with my family*
- 6. Not being a financial burden to my family*

*If I am having significant pain or suffering, I would like my doctors to consult a Supportive and Palliative Care Team to help treat my physical, emotional and spiritual discomfort, and to support my family.*

#### My Preferences in Specific Circumstances

In addition to the general advance care goals provided above, below are specific treatment preferences with respect to certain specific circumstances or situations.

If my health ever deteriorates due to a terminal illness, and my doctors believe I will not be able to interact meaningfully with my family, friends, or surroundings, *I prefer that they stop all life-sustaining treatments and let me die as gently as possible. I realize that I will not receive life-sustaining treatments including but not limited to breathing machines, blood transfusions, dialysis, heart machines, and IV drugs to keep my heart working. I also realize that medical personnel will not attempt cardiopulmonary resuscitation (CPR), and they will allow me to die naturally.*

If I have a severe, irreversible brain injury or illness and can't dress, feed, or bathe myself, or communicate my medical wishes, but doctors can keep me alive in this condition for a long period of time, *I would like for them to keep trying life-sustaining treatments for 2 months.*

Although I understand that, depending on the situation and circumstances, medical personnel may not be able to follow my wishes, here are my general thoughts on cardiopulmonary resuscitation (CPR):



## Universal Advance Digital Directive (uADD)™

**Roger Rienman McBee**Part 2 *cont.*

*I want CPR attempted unless my doctor says I have a terminal illness or a severe, irreversible brain injury, OR I have little chance of long-term survival if my heart or breathing stop, and an attempt to resuscitate me would cause me significant suffering, OR it simply will not work in my condition.*

**Other Instructions**

If it were possible to choose, here is where I would like to spend my final days:

*At home. I would like to receive hospice care at home if possible.*

Unless I have stated otherwise somewhere else in this uADD™, I understand that my healthcare agent may reconsider my medical treatment choices expressed above in light of my other instructions contained elsewhere in this uADD™ or new medical information.



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### Part 3

#### Decisions on Organ Donation and Autopsy

##### Consent to Donate

*I consent to donate the following organs and tissues: Heart, Kidneys, Eyes.*

##### Autopsy

*I want an autopsy if my doctor thinks it will help others.*



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### Part 4

#### My Thoughts

MyDirectives® offers people a list of optional questions that can be answered by typing text in a text box or by uploading a video or audio file for each question. Only those questions answered by Roger Rienman McBee appear here. For a complete list of questions in My Thoughts, please visit [www.MyDirectives.com](http://www.MyDirectives.com).

In case I'm being cared for by a person(s) who doesn't know me very well, I'd like my following thoughts to be known.

**My likes / joys:** Here are some examples of the things that I would like to have near me, music that I'd like to hear, and other details of my care that would help to keep me happy and relaxed:

*Like Bach, especially the cantatas. St. Martin in the Fields.*

**How to care for me:** If I become incapacitated and cannot express myself, here is what I would like to tell my healthcare agent, family and friends about how I would like for them to care for me:

*I don't like being treated like an object. I would like to be greeted like a person before working on me.*

**My religion:** If I appear to be approaching the end of my life, here are some things that I would like for my caregivers to know about my faith and my religion. Please attempt to notify someone from the *Not Religious* religion at the following phone number, if I have included one.

**My unfinished business:** If it appears that I am approaching the end of my life, and I cannot communicate with persons around me, I would want my doctors and nurses, my family, and my friends to know about some unfinished business that I need to address:

*I am awaiting a message from the Noble Committee. Please keep me alive if I look promising this year.*

**If I were to pass away:** Here are my thoughts on funeral or burial plans:

*I have a plot. My wife has the details, also my secretary, Ms. Williams, will know.*



## Universal Advance Digital Directive (uADD)™

**Roger Rienman McBee**

## Part 5

**Making the uADD™ Legal**

I am emotionally and mentally competent to make this uADD. I understand the purpose and effect of this uADD, I agree with everything that is written in this uADD, and I have made this uADD knowingly, willingly and after careful deliberation.

*Roger R McBee*

7/31/2014

Signature (or my signature signed by the person named below)

Date

**Statement of Witnesses**

I declare that the person who signed this uADD, or who asked another to sign this uADD on his/her behalf, is the individual identified in the document, and he/she did so in my presence. I believe him/her to be of sound mind and at least 18 years of age. I personally witnessed him/her sign this document or ask the person indicated to do so, and I believe that he/she did so voluntarily. By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not related to the person signing this document by blood, marriage or adoption.
- Not a healthcare agent appointed by the person signing this document.
- Not directly financially responsible for that person's healthcare.
- Not a healthcare provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain), officer, director, or partner of a healthcare provider (or any parent organization of such healthcare provider) directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

**Witness Number 1:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Witness Number 2:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Universal Advance Digital Directive (uADD)™

**Roger Rienman McBee****Part 5** *cont.***Instructions for Notarization:**

Residents of certain jurisdictions are required to have the uADD signed by a notary public registered in their jurisdiction, in addition to having witnesses sign the uADD. Other jurisdictions allow the uADD to be signed by a notary public without requiring witnesses.

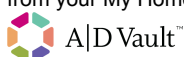
**Notary Public**

In my presence on \_\_\_\_\_ (date), \_\_\_\_\_ (name) acknowledged his/her signature on this uADD or acknowledged that he/she authorized the person signing this uADD to sign on his/her behalf. I am not named as a healthcare agent or alternate healthcare agent in this document.

Signature of Notary \_\_\_\_\_

My commission expires on \_\_\_\_\_ (date)

To provide your hospital/healthcare provider with a link to an Official Copy of this document, click "Send to Doctor or Hospital" from your My Home page at [www.mydirectives.com](http://www.mydirectives.com).



For more information, contact MyDirectives® at [info@mydirectives.com](mailto:info@mydirectives.com) or <http://www.mydirectives.com>