ADVANCE DIRECTIVE

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Standard PDF:

Table headers: 0:
THIS FORM CONTAINS 2 PARTS (EACH PART IS OPTIONAL): br/PART I. MEDICAL POWER OF ATTORNEY br/PART II. LIVING WILL br/PART I. MEDICAL POWER OF ATTORNEY br/PART II. LIVING WILL br/A living will allows a principal to select end-of-life treatment options in the chance of incapacitation with no viable cure. br/B. LIFE SUPPORT. br/C. CERTAIN LIFE-SUSTAINING TREATMENT. br/D. END OF LIFE WISHES. (hospice care, funeral arrangements, etc.): br/WITNESSES / NOTARY ACKNOWLEDGMENT. br/WITNESS 1 br/WITNESS 2 br/NOTARY ACKNOWLEDGMENT

Headers: 13:

Check box: 16:
_____ ☐ - Have a medical power of attorney. br/_____ ☐ - Not have a medical power of attorney. Part I of this form is intentionally left br/_____ ☐ - Have a living will. br/_____ ☐ - Not have a living will. Part II of this form is intentionally left blank. br/_____ ☐ - Chronic coma or persistent vegetative state br/_____ ☐ - No longer able to communicate my needs br/_____ ☐ - No longer able to recognize family or friends br/_____ ☐ - Total dependence on others for daily care br/_____ ☐ - Other: _____. br/_____ ☐ - Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV). br/_____ ☐ - If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV). br/_____ ☐ - Cardiopulmonary Resuscitation (CPR) br/_____ ☐ - Ventilation (breathing machine) br/_____ ☐ - Feeding tube br/_____ ☐ - Dialysis br/_____ ☐ - Other: _____.

Paragraph: 61:
An advance directive is a document that allows a principal to select someone else to make health care decisions if they are not able to for themselves. In addition, it will enable a principal to choose their end-of-life treatment options on whether to prolong their life. Depending on State law, this document must be signed in the presence of a notary public and/or two (2) witnesses.
A medical power of attorney allows you the right to name someone else to make health care decisions on your behalf.
I choose to: (initial and check) (choose one)
_____ ☐ - Have a medical power of attorney.
_____ ☐ - Not have a medical power of attorney. Part I of this form is intentionally left blank.
A. PRINCIPAL. I, _____, with a mailing address of _____, City of _____, State of _____, Zip Code: _____ (“Principal”) hereby designate:
B. AGENT. _____, with a mailing address of _____, City of _____, State of _____, Zip Code: _____ (“Agent”).
AGENT’S TELEPHONE (CELL): (____) ____-_____
I select the above-named person as my Agent to act in all matters relating to my health care (including my mental health care) and including, without limitation, the power to give or refuse consent to all medical and surgical treatments, hospitalizations, and all related health care. This power of attorney is effective at the point when I am no longer able to communicate my health care wishes. My Agent's decisions under this power of attorney, during any period when I am unable to make and/or communicate my health care decisions or when there is uncertainty as to whether I

am dead or alive, are binding on my heirs, devisees, and personal representatives.
C. ALTERNATE AGENT. If my Agent is unable or unwilling to serve or make a decision in a timely manner, I select _____, with a mailing address of _____, City of _____, State of _____, to act as my alternate agent ("Alternate Agent"):
ALTERNATE AGENT'S TELEPHONE (CELL): (____) ____-_____
I intend for my Agent to receive any and all of my health records and information as if I were the one requesting such information. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1420D, and 45 CFR 160-164.
I choose to: (initial and check) (choose one)
_____ ☐ - Have a living will.
_____ ☐ - Not have a living will. Part II of this form is intentionally left blank.
A. PRINCIPAL. I, _____, with a mailing address of _____, City of _____, County of _____, State of _____, with the last four (4) digits of my social security number (SSN) being XXX - XX - _____ ("Principal") desire to advise my doctors and medical providers of my wishes for my health care in the event I am not able to communicate my wishes.
I desire that my doctor make a concerted effort to return me to an acceptable quality of life using then available treatments and therapies. However, if my quality of life becomes unacceptable as I have defined below, and my doctors have determined that my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.
An unacceptable quality of life means (initial and check all that apply):
_____ ☐ - Chronic coma or persistent vegetative state
_____ ☐ - No longer able to communicate my needs
_____ ☐ - No longer able to recognize family or friends
_____ ☐ - Total dependence on others for daily care
_____ ☐ - Other: _____.
(initial and check) (choose one)
_____ ☐ - Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).
_____ ☐ - If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).
Some people do not wish to have certain life-sustaining treatments under any circumstance, even if recovery is a possibility. Check the treatments below, if any, that you do not wish to have under any circumstances:
(initial and check) (choose one)
_____ ☐ - Cardiopulmonary Resuscitation (CPR)
_____ ☐ - Ventilation (breathing machine)
_____ ☐ - Feeding tube
_____ ☐ - Dialysis
_____ ☐ - Other: _____.
When I am near death, it is important to me that: _____
_____
Principal's Signature:
Print Name: _____
Depending on your State's laws, you either two (2) witnesses and/or notary public may be required for signing this form.
On the date set forth above, I hereby state as follows:
The above-named person is personally known to me, and I believe him/her to be of sound mind and to have voluntarily executed this document. I am at least 18 years old, not related to him/her by blood, marriage or adoption, and I am not an Agent or successor Agent named in this document. To my knowledge, I am not a beneficiary of his/her will or any codicil, and I have no claim against

his/her estate. I am not directly involved in his/her health care.

_____
Signature: Date: _____
Print Name: _____

_____
Signature: Date: _____
Print Name: _____
State of _____ }
County of _____ }
Signed and sworn to me on the ____ day of _____, 20____.
I, the undersigned authority in and for said County in said State, hereby certify that the Principal, _____, whose name is signed above in this living will, and who is known to me, acknowledged before me on this day that, being informed of the contents of the said document, (s)he executed the same voluntarily on the day the same bears date.
Given under my hand this ____ day of _____, 20____.

_____
Notary Public Signature:
Printed Name: _____
My commission expires: _____
(Notary Seal)

Embedded Files:

Natural Language:

Table count: 0

Table Parag Count: 0:

Table table row: 0:

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