MyCareVoice.com
ADVANCE DIRECTIVE SOLUTIONS

DIGITAL ADVANCE DIRECTIVE FOR HEALTH CARE

If I, John Jacob, am incapable of making an informed decision regarding my health care, I direct my health care providers follow my instructions below.

I. Appointment of My Health Care Proxy

If I am unable to make decisions regarding my own health care and my attending physician and another physician determine and agree that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers to follow the instructions of the below health care agents. If my state has a different manner of determining whether I am unable to make decisions regarding my own health care then my state's manner of making such a determination should be followed.

Primary Agent:

Name: Jan Jacob

Relation to Me: Spouse

Address: 123 W Main St

City / State / Zip: Oologah, OK 74053

Home Phone: 918-000-1234

Cell Phone: 918-111-1234

Email: janj@mail.com

In the event I revoke my Primary Agent's authority or if my Primary Agent is not willing, able or reasonably available to make health care decision(s) on my behalf, I designate as my First Alternate Agent:

First Alternate Agent:

Name: _____

Relation to Me: _____

Address: _____

City / State / Zip: _____

Home Phone: _____

Cell Phone: _____

Email: _____

In the event I revoke my Primary Agent and First Alternate Agent's authority or if my Primary Agent and First Alternate Agent are not willing, able or reasonably available to make health care decision(s) on my behalf, I designate as my Second Alternate Agent:

Second Alternate Agent:

Name: _____

Relation to Me: _____

Address: _____

City / State / Zip: _____

Home Phone: _____

Cell Phone: _____

Email: _____

My health care agent is authorized to obtain and review all medical records and health information about me and is further authorized to make any and all medical treatment decisions I could make if I were able, except that decisions regarding life-sustaining treatment and artificially administered nutrition and hydration can be made by my health care agent or alternate health care agent(s) only as I have indicated in the foregoing sections. To the extent, my wishes are unknown, my health care agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest and according to my personal values to the extent such are known to my agent.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

The individuals I have designated as my Agent or Alternate Agent (s) are at least 18 years old and are **NOT** any of the following:

- My health care provider, an employee, agent, or relative of such health care provider, or an owner, operator of a medical care facility that is treating me (for example, a hospital, nursing home, residential or community care center);
- A person serving as a health care proxy or agent representing 10 or more people;
- A person appointed to make the determination of my capacity to make decisions;
- A person which is subject to a protective order for which I am protected;
- A person appointed to be my guardian or conservator;
- A person whose license as a fiduciary has been revoked or suspended;

- An administrator or employee of a government agency which is financially responsible for my care (unless the person is a blood relative);
- A person who I have disqualified from making health care decisions for me.

II. INSTRUCTIONS FOR MY HEALTH CARE

In the event I have either a terminal condition, am persistently unconscious, or have an end-stage condition, as further described below, and if my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, other health care providers, and my health care agent follow my instructions as set forth below:

(1) *If I have a terminal condition*, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months:

Select only one option

___X___I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

Indicate if applicable

___X___See my more specific instructions in paragraph (4) below.

(2) *If I am persistently unconscious,* that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent:

Select only one option

___X___I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

Indicate if applicable

_____See my more specific instructions in paragraph (4) below.

(3) *If I have an end-stage condition*, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective:

Select only one option

__X__I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

_____I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

_____I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

Indicate if applicable

__X__See my more specific instructions in paragraph (4) below.

(4) OTHER HEALTH CARE INSTRUCTIONS. Here you may describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn, and/or give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition, or

I would like ice chips often

III. Anatomical Gifts and Organ Donation

I (do / do not) consent to donate organs, tissues, or any other part or all of my body if they are medically viable at the time of my death. If yes, I would request that my medical provider and family members follow my wishes to make an organ donation as I have indicated below.

If yes, I consent to donate organs, tissues, or any other part or all of my body for the following purposes:

__X__ I consent to donation for the purpose of transplantation.

_____ I consent to donation for the purpose of advancement of medical science, research, or education.

_____ I consent to donation for the purpose of advancement of dental science, research, or education.

If yes, I direct that at the time of my death, meaning either the irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem, I specifically donate:

_____ My entire body

[OR]

__X__ The following body organ(s) and/or tissues:

_____	Heart	_____	Brain	_____	Corneas
__X__	Lungs	_____	Skin	_____	Bones
_____	Liver	_____	Eyes	_____	Bone Marrow
__X__	Kidneys	_____	Arteries	_____	Ligaments
_____	Intestines	__X__	Blood Vessels	_____	Tendons
_____	Pancreas	_____	Blood / Fluids		

By consenting to and making an anatomical gift, I further understand, consent, and give permission for:

- I understand that my medical providers shall make all decisions, including but not limited to a determination of eligibility for anatomical gift, based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

- My medical providers to perform any and all testing, examinations, and procedures that may be necessary to determine the medical eligibility of this gift.

- The release of any information, including medical information, to determine organ and tissue eligibility.

- Any expenses related to the evaluation, determination of medical eligibility of this gift, recovery, and placement of the organs and tissues will be paid for by the recovery organization(s).

- The donation process may take several hours to complete, and the release to the funeral home and/or medical examiner's office, will occur after the recovery process has been completed.

- I understand that I may revoke my consent to make an anatomical gift at any time.

IV. General Provisions

a. I understand that I must be eighteen (18) years of age or older to execute this form.

b. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.

c. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.

d. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of life-sustaining procedures, and I accept the consequences of such choice or refusal.

e. This advance directive shall be in effect until it is revoked.

f. I understand that I may revoke this advance directive at any time.

g. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.

h. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.

i. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

j. The powers delegated and instructions provided herein are severable, so the invalidity of one or more shall not affect the validity of others.

Signed this 21 day of September, 2021

(Signature)

John Jacob
(Printed Name)

Residence:

Address: 4999 Breeze Dr Dakota City 40505

County of Delaware, State of Utah

Date of birth: 09/01/1995

My Care Voice is meant to help you voice your intentions regarding your medical care wishes. It is not meant to provide legal or medical advice. All states have laws regulating the form and execution of advanced directives and those laws are subject to change. MCV cannot guarantee compliance or that one's wishes will be followed. If you have a question, please speak with a medical or legal professional for advice.