

State of \_\_\_\_\_

# **ADVANCE HEALTH CARE DIRECTIVE**

**This document may be used to make your wishes known regarding what medical treatment or care you do or do not want to receive in the event you are unable to speak for yourself. You should provide a copy to your doctor, family, and friends.**

## **I. ADVANCE HEALTH CARE DECLARATION**

I, \_\_\_\_\_, being of sound mind and legal age, willfully and voluntarily make this declaration to state my desires regarding health care treatment if I am unable to speak for myself. It is my intention that this declaration be honored by my family, my physicians, and all others who may partake in my healthcare.

## **II. DEFINITIONS**

“Artificial nutrition and hydration” is food, supplements, or fluids provided through intravenous (IV) therapy or a feeding tube.

“Life-sustaining treatment” is any mechanical or artificial treatment, procedure, or medication that would prolong the process of dying. Examples of such treatment include antibiotics, artificial respiration, cardiopulmonary resuscitation (CPR), dialysis, transfusions, and ventilation.

“Permanent unconscious state” is a total loss of consciousness from which I am unlikely to recover in the near future. Examples include a persistent vegetative state and irreversible coma.

“Terminal condition” is an irreversible illness that will likely result in my death or a state of permanent unconsciousness from which I am unlikely to recover in the near future.

## **III. POWER OF ATTORNEY FOR HEALTH CARE**

### **DESIGNATION OF AGENT**

In the event I have a terminal condition or am in a permanent unconscious state, or am otherwise unable to speak for myself, I designate the following individual as my agent to make health care decisions for me:



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**Agent's Full Name**

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**Agent's Address**

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City

State

Zip Code

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**Agent's Home Phone****Agent's Other Phone****DESIGNATION OF ALTERNATE AGENT(S)**

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 first alternate agent:

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**First Alternate Agent's Full Name**

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**First Alternate Agent's Address**

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City

State

Zip Code

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**First Alternate Agent's Home Phone****First Alternate Agent's Other Phone**

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

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**Second Alternate Agent's Full Name**

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**Second Alternate Agent's Address**

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City

State

Zip Code

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**Second Alternate Agent's Home Phone****Second Alternate Agent's Other Phone**

### AGENT'S AUTHORITY

My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw life-sustaining treatment, artificial nutrition and hydration, and all other forms of health care treatment to keep me alive, except as I state here:

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### WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE

(PLEASE INITIAL ONE)

My agent's authority becomes effective:

\_\_\_\_\_ When I become incapacitated and cannot make health care decisions on my own.

\_\_\_\_\_ Immediately upon the effective execution of this document.

### AGENT'S OBLIGATION

I direct my agent to make health care decisions for me in accordance with this documents and my other wishes to the extent known to my agent. If my wishes are unknown, my agent shall make health care decisions for me to promote in my best interests and my personal values.

### HIPPA WAIVER

(PLEASE INITIAL ONE)

\_\_\_\_\_ I authorize my health care providers to release my protected health information and medical records to my agent during the period my agent's authority is effective.

\_\_\_\_\_ I DO NOT authorize my health care providers to release my protected health information and medical records to my agent.

### NOMINATION OF GUARDIAN OR CONSERVATOR

If a guardian conservator needs to be appointed for me by a court, I nominate to act as conservator:



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**Conservator's Full Name**

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**Conservator's Address**

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City

State

Zip Code

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**Conservator's Home Phone**

**Conservator's Other Phone**

If the person named above is not willing, able, or reasonably available to act as conservator, I nominate to act as first alternate conservator:

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**First Alternate Conservator's Full Name**

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**First Alternate Conservators Address**

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City

State

Zip Code

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**First Alternate Conservator's Home Phone**

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**First Alternate Conservator's Work Phone**

If the persons named above are willing, able, or reasonably available to act as conservator, I nominate as second alternate conservator:

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**Second Alternate Conservator's Full Name**

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**Second Alternate Conservators Address**

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City

State

Zip Code

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**Second Alternate Conservator's Home Phone**

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**Second Alternate Conservator's Work Phone**



#### **IV. LIVING WILL**

##### **TERMINAL CONDITION**

###### **LIFE-SUSTAINING TREATMENT:**

If I become ill and have a terminal condition:

(PLEASE INITIAL ONE)

\_\_\_\_\_ I direct that life-sustaining measures be administered to prolong my life.

\_\_\_\_\_ I DO NOT want life-sustaining measures to administered.

\_\_\_\_\_ I direct that my agent decide.

###### **ARTIFICIAL NUTRITION AND HYDRATION:**

(PLEASE INITIAL ONE)

\_\_\_\_\_ I direct that artificial nutrition and hydration be administered regardless of my condition.

\_\_\_\_\_ I DO NOT want artificial nutrition and hydration to be administered regardless of my condition.

\_\_\_\_\_ I direct that my agent decide.

##### **PERMANENT UNCONSCIOUS STATE**

###### **LIFE-SUSTAINING TREATMENT:**

If I become ill and fall into a permanent unconscious state:

(PLEASE INITIAL ONE)

\_\_\_\_\_ I direct that life-sustaining measures be administered to prolong my life.

\_\_\_\_\_ I DO NOT want life-sustaining measures to administered.

\_\_\_\_\_ I direct that my agent decide.

###### **ARTIFICIAL NUTRITION AND HYDRATION:**

(PLEASE INITIAL ONE)



\_\_\_\_\_ I direct that artificial nutrition and hydration be administered regardless of my condition.

\_\_\_\_\_ I DO NOT want artificial nutrition and hydration to be administered regardless of my condition.

\_\_\_\_\_ I direct that my agent decide.

#### RELIEF FROM PAIN

(PLEASE INITIAL ONE)

\_\_\_\_\_ I direct that treatment for the alleviation of pain or discomfort be administered, even if it results in the hastening of my death.

\_\_\_\_\_ I DO NOT want treatment for the alleviation of pain or discomfort be administered, even if it results in the hastening of my death.

#### OTHER WISHES

\_\_\_\_\_  
\_\_\_\_\_

### **V. DONATION OF ORGANS AT DEATH**

Upon my death, I give:

(PLEASE INITIAL ONE)

\_\_\_\_\_ I give any needed organs, tissues, or parts

\_\_\_\_\_ I give the following organs, tissues or parts only: \_\_\_\_\_

for the following purposes: (INITIAL ALL THAT APPLY)

\_\_\_\_\_ therapy

\_\_\_\_\_ transplant

\_\_\_\_\_ research

\_\_\_\_\_ education

\_\_\_\_\_ other: \_\_\_\_\_



\_\_\_\_\_ I DO NOT wish to make an anatomical donation.

\_\_\_\_\_ I authorize my agent to donate all or any part of my body for any purposes my agent sees fit.

## **VI. FINAL ARRANGEMENTS**

Upon my death, I direct that my body:

(PLEASE INITIAL ONE)

\_\_\_\_\_ be interred at \_\_\_\_\_.

\_\_\_\_\_ be cremated and placed at \_\_\_\_\_.

\_\_\_\_\_ other: \_\_\_\_\_

\_\_\_\_\_ Upon my death, I authorize my agent to organize my funeral arrangements and provide for the disposition of my body as my agent sees fit.

Other Instructions: \_\_\_\_\_  
\_\_\_\_\_

## **VII. PRIMARY PHYSICIAN**

The following physician shall be my primary physician:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

### **ALTERNATE PRIMARY PHYSICIAN**

If the physician above is unable to act as my primary physician, the following physician shall be my primary physician:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_



### **VIII. SIGNATURE**

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**Your Signature**

Date

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**Your Name**

---

**Your Address**

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City

State

Zip Code

### **IX. ACKNOWLEDGMENT BY AGENT**

I hereby accept and agree to serve as health care agent, and act in accordance with the principal's desires as expressed in this document or otherwise known to me.

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**Agent's Signature**

Date

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**First Alternate Agent's Signature**

Date

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**Second Alternate Agent's Signature**

Date

### **X. WITNESS ATTESTATION AND SIGNATURES**

We declare that the principal who signed this document:

1. Is personally known to us or provided proof of identity;
2. Signed this document in our presence; and
3. Appeared to be of sound mind and free from duress or undue influence.





We are not the individual(s) appoint as the principal's agent or the health care provider or employee of the health care provider of the principal.

FIRST WITNESS

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**First Witness' Signature**      **Date**

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**First Witness' Name**

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**First Witness' Address**

---

City

State

Zip Code

SECOND WITNESS

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**Second Witness' Signature**      **Date**

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**Second Witness' Name**

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**Second Witness' Address**

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City

State

Zip Code



**ACKNOWLEDGEMENT OF NOTARY PUBLIC**

State of \_\_\_\_\_

County of \_\_\_\_\_

On \_\_\_\_\_ before me, \_\_\_\_\_  
personally appeared \_\_\_\_\_, who proved to me on the basis of  
satisfactory evidence to be the person whose name is subscribed to the within instrument and  
acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her  
signature on the instrument the person, or the entity upon behalf of which the person 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)

