Dear {{ users[0] }},

Congratulations! You have completed the interview and your Health Care Directive has been created. Here’s what you can do next.

* **Review your document.**Before you print, read this form closely and make sure it accurately reflects your wishes. If you are using MS Word, you can fix any mistakes you find. If you need to make changes but you don’t have MS Word, you may need to try again using a computer at a library or other public place.
* **Print your form.**If your computer is connected to a printer, you can print this form at any time by clicking on “File,” then selecting “Print” from the drop down menu. You may also print by pressing “p” while holding down the “Ctrl” key. If you don’t have a printer, you can find one at a library.
* **DO NOT sign the form right away.**In order for this form to be valid, you have to sign it in front of a Notary Public, a Court Administrator, OR your two witnesses. Agents do NOT need to sign.
* **Make copies AFTER the form is signed.**   
  Once your form has been signed, you should make copies. Keep the original for yourself – make sure to keep it in a place where other people can get to it. Don’t put it in a safe.
* **Distribute the copies.**   
  Give a copy to anyone you named as an agent or alternate agent. You should also give a copy to your doctor, any medical clinics you visit regularly, and any hospital, nursing home or assisted living facility where you may receive care.

|  |  |
| --- | --- |
| **Notice to My Doctors**  In the event of an emergency,  Please consult my Health Care Agent  Name: {{ agents[0] }} Phone: {{ agents[0].phone\_number }} | **I have a Health Care Directive.** It is located here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Signature* |

You can cut out this card, fold it, laminate it, and carry it in your wallet.

Make sure to change the card if your Agent’s phone number changes.

Keep this form with other personal papers in a safe place where others can get it, not in a safe deposit box. Give signed copies to doctors, family, close friends and any agent or alternate agent you named. Ask to have it put in your file at your doctor’s office and the hospital, home care agency, hospice or nursing home. Make sure your doctor is willing to follow your wishes.

|  |
| --- |
| **Health Care**  **Directive** |

{{ users[0] }}

{{ today() }}

**I,** {{ users[0] }}, understand this document allows me to do ONE OR BOTH of the following:

**Part I:** Name one person or two persons (called the health care agent(s)) to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or must act in my best interest if I have not made my health care wishes known.

**AND/OR**

**Part II:** Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care, and my family, in the event I cannot make decisions for myself.

**Part I: Appointment of Health**

This is who I want to make health care decisions for me if I am unable to decide or speak for myself (I know I can change my agent or alternate agent at any time and I know I do not have to appoint an agent or an alternate agent). NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II.

When I am unable to decide or speak for myself, **I trust and appoint**  {{ agents[0] }} to make health care decisions for me. This person is called my health care agent.

Relationship of my health care agent to me: {{ agents[0].relationship }}

Telephone number of my health care agent: {{ agents[0].phone\_number }}

Address of my health care agent: {{ agents[0].address.on\_one\_line() }}

My health care Agents must act jointly and be in agreement when making decisions.

(Optional) Appointment of Alternate Health Care agent(s): If my health care agent is not reasonably available, I trust and appoint the following alternatives to be my health care agent, to be appointed in the order listed. I trust and appoint {{ agents[1] }} to be my health care agent instead.

Relationship of my first alternative health care agent to me: {{ agents[1].relationship }}

Telephone number of my first alternative health care agent: {{ agents[1].phone\_number }}

Address of my first alternative health care agent: {{ agents[1].address.on\_one\_line() }}

Relationship of my second alternative health care agent to me: {{ agents[2].relationship }}

Telephone number of my second alternative health care agent: {{ agents[2].phone\_number }}

Address of my second alternative health care agent: {{ agents[2].address.on\_one\_line() }}

Relationship of my third alternative health care agent to me: {{ agents[3].relationship }}

Telephone number of my third alternative health care agent: {{ agents[3].phone\_number }}

Address of my third alternative health care agent: {{ agents[3].address.on\_one\_line() }}

Relationship of my fourth alternative health care agent to me: {{ agents[4].relationship }}

Telephone number of my fourth alternative health care agent: {{ agents[4].phone\_number }}

Address of my fourth alternative health care agent: {{ agents[4].address.on\_one\_line() }}

**THIS IS WHAT I WANT MY HEALTH CARE AGENT**

**TO BE ABLE TO DO IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF**

**(I know I can change these choices)**

My health care agent is automatically given the powers listed below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

Whenever I am unable to decide or speak for myself, my health care agent has the power to:

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.

(B) Choose my health care providers.

(C) Choose where I live and receive care and support when those choices relate to my health care needs.

(D) Review my medical records and have the same rights that I would have to give my medical records to other people.

If I DO NOT want my health care agent to have a power listed above in (A) through (D) OR if I want to LIMIT any power in (A) through (D), I MUST say that here: {{ power\_limitations }}

My health care agent is NOT automatically given the powers listed below in (1) and (2). If I WANT my agent to have any of the powers in (1) and (2), I must INITIAL the line in front of the power; then my agent WILL HAVE that power.

{{ initial\_bodypart }} (1) To decide whether to donate any parts of my body, including organs, tissues, and eyes, when I die.

{{ initial\_burial }} (2) To decide what will happen with my body when I die (burial, cremation).

If I want to say anything more about my health care agent’s powers or limits on the powers, I can say it here:

{{ power\_comments }}

**Part II: Health Care Instructions**

NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you MUST complete some or all of this Part II if you wish to make a valid health care directive.

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs). THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE (I know I can change these choices or leave any of them blank)

I want you to know these things about me to help you make decisions about my health care:

1. My goals for my health care: {{ health\_care\_goals }}
2. My fears about my health care: {{ health\_care\_fears }}
3. My spiritual or religious beliefs and traditions: {{ spiritual\_religious\_beliefs }}
4. My beliefs about when life would be no longer worth living: {{ life\_worth\_living }}
5. My thoughts about how my medical condition might affect my family: {{ effect\_on\_family }}
6. (For a woman of childbearing age) My thoughts about how my health care should be handled in the event I am pregnant: {{ health\_care\_if\_pregnant }}
7. My personal statement to my loved ones and caretakers: {{ statement\_to\_loved\_ones }} **THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE**

**(I know I can change these choices or leave any of them blank)**

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics, and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help.

**This is how I feel about specific medical procedures:**

1. Dialysis: {{ dialysis\_thoughts }}
2. Cardiopulmonary Resuscitation (CPR):{{ resuscitation\_thoughts }}
3. Intubation: {{ intubation\_thoughts }}
4. CPAP and BiPAP: {{ cpap\_and\_bipap\_thoughts }}
5. Nutrition support and hydration (feeding tubes): {{ feeding\_tubes\_thoughts }}
6. Antibiotics: {{ antibiotics\_thoughts }}

**I have these views about my health care in these situations:**

(NOTE: You can discuss general feelings specific treatments, or leave any of them blank)

1. If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want: {{ reasonable\_chance\_thoughts }}
2. If I were dying and unable to decide or speak for myself, I would want: {{ dying\_unable\_to\_speak\_thoughts }}
3. If I were permanently unconscious and unable to decide or speak for myself, I would want:  
   {{ permanently\_unconcious\_thoughts }}
4. If I were completely dependent on others for my care and unable to decide or speak for myself, I would want: {{ completely\_dependent\_thoughts }}
5. In all circumstances, my doctors will try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life: {{ pain\_relief\_thoughts }}

**There are other things that I want or do not want for my health care, if possible:**

1. Who I would like to be my doctor: {{ preferred\_doctor }}

2. Where I would like to live to receive health care: {{ where\_to\_receive\_healthcare }}

3. Where I would like to die and other wishes I have about dying: {{ where\_to\_die }}

4. My wishes about donating parts of my body when I die: {{ donating\_bodyparts }}

5. My wishes about what happens to my body when I die (cremation, burial): {{ cremation\_or\_burial }}

**Part III: Making The Document Legal**

This document must be signed by me. It also must be verified either by a notary public (Option 1) OR witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed.

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

Signature of {{ users[0] }},

Principal

If I cannot sign my name, I can ask someone to sign this document for me.

Date signed: {{ signature\_date}} Date of birth: {{ users[0].birthdate }}

Address: {{ users[0].address.line\_one() }} {{ users[0].address.line\_two() }}

{{ other\_signor }}

Signature of person who I asked to Printed name of person who I asked to

Sign this document for me sign this document for me

**Option 1: Notary Public**

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

Subscribed and sworn to before me this

day of , .

Notary Public

**Option 2: Witnesses**

Two witnesses must sign. Only one of the two witnesses can be a health care provider or an employee of a health care provider giving direct care to me on the day I sign this document.

Witness One:

(i) In my presence on {{ signature\_date}} (date), {{ witnesses[0] }} (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.

1. I am not named as a health care agent or an alternate health care agent in this document.
2. If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (i), I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

(Signature of {{ witnesses[0] }}

Address: {{ witnesses[0].address.line\_one() }} {{ witnesses[0].address.line\_two() }}

Witness Two:

(i) In my presence on {{ signature\_date}} (date), {{ witnesses[1] }} (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.

1. I am not named as a health care agent or an alternate health care agent in this document.
2. If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (i), I must initial this box: [ ]

I certify that the information in (i) through (iv) is true and correct.

(Signature of {{ witnesses[1] }}

Address: {{ witnesses[1].address.line\_one() }} {{ witnesses[1].address.line\_two() }}