**For more information on the importance of having an Advance Directive and Medical Power of Attorney please go to the Alcor Website for two detailed articles by attorney Rebecca Lively.**

[**http://alcor.org/Library/html/medical-power-of-attorney-for-cryonics.html**](http://alcor.org/Library/html/medical-power-of-attorney-for-cryonics.html)

[**http://alcor.org/BecomeMember/toprotectarrangements.html**](http://alcor.org/BecomeMember/toprotectarrangements.html)

**If you would like this in a word document for easier implementation, please send request to diane@alcor.org**

**ADVANCE DIRECTIVE AND MEDICAL POWER OF ATTORNEY INSTRUCTIONS**

*Disclaimer: This document is meant to help you express your wishes in a form that substantially complies with your state’s requirements for an advance directive and medical power of attorney.*

*This directive is not mandatory and is provided only for personal convenience. This is not intended as legal advice and cannot answer every question you may have. This form is not regularly updated to incorporate changes in state law. Nothing can substitute for advice from your attorney and your doctor. If you have a specific question or concern, consult your doctor or attorney.*

***Please forward to Alcor for your file any advance directive and medical power of attorney for healthcare you put in place. A copy should also be kept with your copy of your Alcor paperwork.***

Instructions for completing this document:

This document is an important legal document which you can use to communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. This document also names individuals who you want to make medical decisions for you if you are unable to make them for yourself. These wishes are usually based on personal values. This particular form is designed for people who have elected to be preserved through cryonics after legal death.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson,

you and the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and those who you appoint to make medical decisions for you if you cannot care for yourself. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

**ADVANCE DIRECTIVE AND MEDICAL POWER OF ATTORNEY**

Definitions:

"Artificial nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

"Irreversible condition" means a condition, injury, or illness:

(1) which may be treated, but is never cured or eliminated;

(2) which leaves a person unable to care for or make decisions for the person's own self; and

(3) which, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

"Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

"Terminal condition" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.

**MY INFORMATION**

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

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Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DIRECTIVE**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

I have entered into an agreement dated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to have my body cryopreserved upon being pronounced clinically and legally dead. This agreement is with the Alcor Life Extension Foundation, 7895 East Acoma Drive, Suite 110, Scottsdale, AZ 85260, (800) 367-2228 or (480) 922-9013. The Alcor Life Extension Foundation will hereafter be referred to as “Alcor.”

I have a strong personal belief in cryopreservation. My agreement with Alcor is related to the disposition of my remains after death. Immediately after my legal death, it is my desire that my human remains be donated to Alcor without embalming or autopsy. While I strongly object to autopsy, if it is determined that an autopsy is legally necessary, it is my desire that the autopsy be conducted at a low temperature and in as non-invasive a way as possible and without damaging or dissecting my brain. Nothing in this document should be construed as contrary to my arrangements with Alcor.

**IF I HAVE A TERMINAL CONDITION**

If in the judgment of both my physician and another health care professional I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care, I direct the following (choose any or all of the following by placing your initials beside your selection):

\_\_\_\_\_I direct that all health care decisions be guided by the objective of preserving my brain throughout the terminal and dying phase and ensuring cryopreservation can begin as soon as possible after my legal death.

\_\_\_\_\_I direct that measures to prolong my life should only be initiated or accepted if they result in less damage to my brain.

\_\_\_\_\_I direct that Alcor be called as soon as possible at (800) 367-2228 or (480) 922-9013 so that, if possible, a stand-by team can be present prior to my legal death.

\_\_\_\_\_I direct that Alcor or the entity aiding in my cryopreservation be consulted to assist in making decisions about my care that will optimize my future cryopreservation.

\_\_\_\_\_I direct that if possible when terminal I want to be transferred to hospice care in the Phoenix/Scottsdale area near Alcor.

\_\_\_\_\_I direct that my Power of Attorney have access to and control over my medical records and to have the authority to discuss those records with health care providers.

\_\_\_\_\_I direct that my Power of Attorney and Alcor personnel or the entity aiding in my cryopreservation be considered my family and allowed to visit me.

Additionally, I direct the following (provide your wishes in the space below, refer to an attachment or cross out these lines):

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

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**IF I AM IRREVERSIBLY MENTALLY DISABLED**

If in the judgment of both my physician and another health care professional I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care, I direct the following

(choose ONLY ONE of the following by placing your initials beside your selection)

\_\_\_\_\_So long as my brain **is not** deteriorating, I direct that life-sustaining treatment be continued until Alcor is available to provide a stand-by team to be at my bedside as life-sustaining treatment is discontinued.

\_\_\_\_\_So long as my brain **is not** deteriorating, I direct that I be kept alive in this irreversible condition using available life-sustaining treatment to include artificial nutrition and hydration.

(choose any or all of the following by placing your initials beside your selection)

\_\_\_\_\_I direct that all health care decisions be guided by the objective of preserving my brain and ensuring cryopreservation can begin as soon as possible after my legal death.

\_\_\_\_\_I direct that measures to prolong my life should only be initiated or accepted if they result in less damage to my brain.

\_\_\_\_\_I direct that Alcor be called as soon as possible at (800) 367-2228 or (480) 922-9013 so that, if possible, a stand-by team can be present prior to my legal death.

\_\_\_\_\_I direct that Alcor or the entity aiding in my cryopreservation be consulted to assist in making decisions about my care that will optimize my future cryopreservation.

\_\_\_\_\_I direct that my Power of Attorney have access to and control over my medical records and to have the authority to discuss those records with health care providers.

\_\_\_\_\_I direct that my Power of Attorney and Alcor personnel or the entity aiding in my cryopreservation be considered my family and allowed to visit me.

Additionally, I direct the following (provide your wishes in the space below, refer to an attachment or cross out these lines):

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

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**OTHER SITUATIONS WHERE I AM NEAR DEATH**

If neither of the two above sections apply but I am or may be near death, my primary goal is to be returned to a healthy life or to a conscious state so I can make my own health care decisions. If that is not possible or likely, I direct the following (choose any or all of the following by placing your initials beside your selection)

\_\_\_\_\_I direct that all health care decisions be guided by the objective of preserving my brain and ensuring cryopreservation can begin as soon as possible after my legal death.

\_\_\_\_\_I direct that measures to prolong my life should only be initiated or accepted if they result in less damage to my brain.

\_\_\_\_\_I direct that Alcor be called as soon as possible at (800) 367-2228 or (480) 922-9013 so that, if possible, a stand-by team can be present prior to my legal death.

\_\_\_\_\_I direct that Alcor or the entity aiding in my cryopreservation be consulted to assist in making decisions about my care that will optimize my future cryopreservation.

\_\_\_\_\_I direct that my Power of Attorney have access to and control over my medical records and to have the authority to discuss those records with health care providers.

\_\_\_\_\_I direct that my Power of Attorney and Alcor personnel or the entity aiding in my cryopreservation be considered my family and allowed to visit me.

Additionally, I direct the following (provide your wishes in the space below, refer to an attachment or cross out these lines):

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

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**MEDICAL POWER OF ATTORNEY**

When selecting your agent, please select someone who is at least 18 years old (21 years in Colorado) and who is NOT your health care provider (including an owner or operator of a health or residential community serving you), an employee or spouse of an employee of your health care provider, OR a person who is already serving as an agent or proxy for ten or more people (unless they are also your spouse or close relative).

If I am no longer able to make my own health care decisions, I name the below individuals to make these decisions for me consistent with my directives above. This person will be my health care agent (or other term that may be used in my state, such as proxy, representative, or surrogate). This designation takes effect immediately if I become unable to make my own health care decisions even if a formal determination of incompetency has not been made, unless state law requires a formal determination.

I appoint the following to be my health care agent:

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

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If the person designated as my agent is unable or unwilling to make health care decisions for me, or if the person designated above is divorced or legally separated from me after the date of this agreement, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order unless divorced or legally separated from me after the date of this agreement:

SECOND CHOICE:

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

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Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THIRD CHOICE:

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

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Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:**

In addition to the limits discussed in my directive, I request my agent contact Alcor at (800) 367-2228 or (480 922-9013 as soon as possible at any time they believe that I have a significant chance of death or brain damage. After contacting Alcor, I request that all medical decisions be made with the primary goal that I be returned to a healthy life. However, if that is not possible, I request that my agent consult with Alcor to make health care decisions consistent with my wish to be cryopreserved as soon as possible following my legal death.

The following listed individuals have made it known to me that they are unwilling or unable to follow my wishes with regard to cryopreservation. Accordingly, I direct that the following individuals be excluded from serving as my health care agent under any circumstance

(list names only below – you should only list people who might have a legal reason to assert themselves as your health care proxy. Generally, there is no need to list non-family members):

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

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**This document should be executed before two witnesses (and in some cases a notary)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, direct that my doctors, my health care agents, and all others, follow my wishes as communicated in this Advance Directive and Medical Power of Attorney. This document becomes valid when I am unable to make decisions or speak for myself. If any part of this document cannot be legally followed, I ask that all other parts of this document be followed. I also revoke any health care advance directives or medical powers of attorney I have made before.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_

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

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witnesses (you should choose witnesses who can attest to the following statement)**

We, the witnesses, declare that the person who signed or acknowledged this form (hereafter “person”) is personally known to me, that they acknowledged this document in my presence, and that they appear to be of sound mind and under no duress, fraud, or undue influence. Additionally, I am over 18 years of age and am not any of the following: the individual appointed as health care agent or alternate in this document, the person’s health care provider, including owner or operator of a health, long-term care, or other residential or community care facility serving the person, an employee of the person’s health care provider, financially responsible for the person’s health care, an employee of a life or health insurance provider for the person, related to the person by blood, marriage, or adoption, to the best of my knowledge, a creditor of the person or entitled to any part of their estate under a will or codicil, or by operation of law.

We declare that the person who signed or acknowledged this form is personally known to me, that he or she signed or acknowledged this document in my presence, and that he or she appears to be of sound mind and under no duress, fraud, or undue influence.

(Not all of the above restrictions apply in every state. However, unless you know your states rules, please follow all of the above)

SIGNATURE OF FIRST WITNESS.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_

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

SIGNATURE OF SECOND WITNESS.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_

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

**NOTARIZATION** (Required in Missouri, North Carolina, South Carolina, and West Virginia)

For Missouri, only your signature need be notarized, in other states, you should have your signature and the signatures of your witnesses notarized.

STATE OF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COUNTY OF\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On this\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_, the said \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, known to me (or satisfactorily proven) to be the person named in the foregoing instrument and witnesses, respectively, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

**Affidavit**

I have reviewed this Advance Directive and Medical Power of Attorney and do hereby affirm that this document does still express my wishes.   I plan to make such a confirming affidavit every five to ten years so that there will be no question about my wishes as time passes.

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

Name                                                                                              Date