**ADVANCE MEDICAL DIRECTIVE**

I, [NAME], [s/o or d/o or w/o] aged [AGE] years, [NATIONALITY], residing at [ADDRESS], holding Aadhar Card number [NUMBER] OR Passport No. [NUMBER] hereby express my wishes and issue the following directives regarding withholding or withdrawing medical care to be provided to me:

1. In the event that I suffer from a terminal disease or illness and if further life sustaining medical care will only delay death but cause prolonged anguish, pain, suffering and loss of dignity to me, I hereby direct my treating physician and/or other medical professionals who may be involved in my treatment to withdraw and withhold further medical treatment in accordance with the requirements and stipulations made hereunder and in law, including those that are set out in the judgements of the Hon’ble Supreme Court of India in this regard.
2. In the event that I become unconscious or incapable of taking a decision, I hereby authorize the following persons to convey my wish to my treating physician and/or other medical professionals who may be involved in my treatment to withdraw and withhold further medical treatment, including but not limited to efforts to resuscitate me; the same may be deemed to be consent given by me for the same.
3. [NAME], [s/o or d/o or w/o] aged [AGE] years, [NATIONALITY], residing at [ADDRESS], holding Aadhar Card number [NUMBER] OR Passport No. [NUMBER]
4. [NAME], [s/o or d/o or w/o] aged [AGE] years, [NATIONALITY], residing at [ADDRESS], holding Aadhar Card number [NUMBER] OR Passport No. [NUMBER]
5. I make it clear that I may revoke the aforesaid authority at any time prior to becoming unconscious or incapable of taking a decision regarding withholding or withdrawing further life sustaining medical care. I hereby revoke all existing Advance Medical Directives made by me.
6. I hereby declare that I have understood the consequences of issuing these directions and authorizing the aforesaid persons to convey these directions and my consent for withdrawal or withholding of further life sustaining medical care.
7. I state that this Advance Medical Directive has been made by me voluntarily and out of my own free will and while I am of sound mind; the same has not been made by me under coercion, inducement, misrepresentation, or while under influence of alcohol, drug, or substance.

[Name of the Executor]

Date

Place:

We hereby attest that this Advance Medical Directive has been signed by [Mr./Ms][NAME], [s/o or d/o or w/o] aged [AGE] years, [NATIONALITY], residing at [ADDRESS], holding Aadhar Card number [NUMBER] OR Passport No. [NUMBER] at [Place] on [Date] in the our presence.

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| Witness 1 | Witness 2 |
| [NAME]  [ADDRESS]  [AADHAR CARD NO]  Date:  Place | [NAME]  [ADDRESS]  [AADHAR CARD NO]  Date:  Place |

Before me

This document has been executed voluntarily and without any coercion or inducement or compulsion and with full understanding of all relevant information and consequences.

(NOTARY PUBLIC) OR (GAZETTED OFFICER)

Date: Date:

Place: Place: