Jane Doe
(DOB: 03/21/1954)
June 26, 2012

Health Proxy

This document shall take effect in the event that I become unable to make or communicate my health care decisions. I authorize my health proxy to get access to all my health records once this directive becomes active.

My health proxy should follow what health care instructions (life support, artificial nutrition and hydration, etc) I specify in this directive, and may not contradict those instructions.

I, Jane Doe, hereby appoint the following person as my health proxy. In the event that this person is unable, unwilling, or reasonably unavailable to act as my agent, I hereby appoint my alternate.

Health Proxy

John Doe
123 Main st.
Chapel Hill, NC 27516
555-555-5555
555-555-5555
John.Doe@gmail.com

Alternate Proxy

Andrew Smith
123 Doty St.
New York City, NY 11218
555-555-5555
555-555-5555
Andrew.Smith@gmail.com

Living Will

I, Jane Doe, being of sound mind, make this statement as a directive to be followed in any of the following circumstances:

- If my doctors reason I am close to death and life support would only postpone the moment of my death.
- If I am in a deep coma, persistent vegetative state, or have suffered other severe neurologic injury which my doctors reason is irreversible.
- If I am irreversibly demented to the point that I can no longer recognize my friends and family nor can I convey my wishes about medical care.
- If my doctors reason I have a serious and irreversible condition or illness that I am unlikely to recover from, and I am no longer able to communicate my wishes.

In the circumstances specified above, I direct my doctors to act in accordance with the following wishes:

In regard to life sustaining treatment:

I would like all available treatment, including life-support treatment, however if the treatment is not improving my condition I request that it be stopped.

In regard to artificial nutrition and hydration:

I do not want to be fed or hydrated by any artificial means.

In regard to relief of pain and suffering:

I would like every attempt to be made to minimize my suffering, even if it may hasten my death.

Organ Donation:

Upon my death, I give any needed organs, tissues, or parts.
My gift is for the following purposes:

- Transplant
- Therapy
- Research
- Education

Signatures

These directions express my legal right to determine the level and extent of my own medical treatment. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind. I understand that I may revoke this advance directive at any time. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked. I understand the full importance and meaning of this advanced directive, and I am emotionally and mentally competent to state my wishes here. If I have appointed a health care proxy or agent, I request that this document guide his or her decisions about my medical care.

Jane Doe

Signature _____ Date _____

Statement of Witnesses

I declare that the person who signed this document appeared to execute the living will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

I also declare that I am not the person's above appointed health proxy; I am not the person's healthcare provider, nor an employee or employer thereof; I am not financially responsible for the person's health care; I am not an employee of any insurance provider for the person; I am not a creditor to the person nor entitled to any portion of the person's estate by way of will or other legal document; I am not related by blood, adoption, or marriage to the person.

Witness 1

Name _____

Signature _____ Date _____

Address _____

_____

Witness 2

Name _____

Signature _____ Date _____

Address _____

_____

Primary Care Physician (Optional)

Name _____

Signature _____ Date _____

Notarization

I, _____, a licensed Notary Public, hereby certify that the principal named above appeared before me and swore to me and to the witnesses in my presence that this instrument is an advance directive document, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it. I further certify that _____ and _____, witnesses, appeared before me and swore that they witnessed the principal named above sign the attached health care power of attorney, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing (i) they were not related within the third degree to him/her or his/her spouse, and (ii) they did not know nor have a reasonable expectation they they would be entitled to any portion of his/her estate upon his/her death under any will or codicil thereto then existing or under the Intestate Succession Act as it provided at that time, and (iii) they were not a physician attending him/her, nor an employee of an attending physician, nor an employee of a health facility in which he/she was a patient, nor an employee of an nursing home or any group-care home in which he/she resided, and (iv) they did not have a claim against him/her. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This the _____ day of _____, 20 _____

Country of _____

State of _____

Notary Public _____

My commission Expires: _____