MyDirectives®

Universal Advance Digital Directive (uADD™)

tst-Lisa tst-Vidall

Important note to readers of this document:

To verify this document is the current version for tst-Lisa tst-Vidall, please click here, or go to https://mydirectives.com/verify and enter this ID: **b2a8fa5** and this check sum: **yHT5qDj0CZ**, or scan the QR code on the left.

It is very important for you to discuss your medical treatment goals and wishes with your healthcare agent, your family, and your medical care providers. Keep in mind that advance medical directives are simply expressions of your medical treatment goals and preferences. There is no guarantee that your medical care providers will follow all of your wishes, but one thing is certain: **If your advance medical directives cannot be quickly located and retrieved in a time of need, then medical care providers, your family and friends will not be able to take your wishes into consideration when they make critical decisions regarding your treatment.**

Part 1 Appointment of a Primary Healthcare Agent and Alternate Healthcare Agents

No answer given to this question.

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Part 2 Expression of Healthcare Treatment Wishes and Desires

If I cannot express my own wishes for medical treatment, I would like the doctors treating me, as well as my healthcare agent if I have chosen one, to make decisions based as much as possible and appropriate on my instructions below.

My Preferences in Specific Circumstances

In addition to the general advance care goals provided above, below are specific treatment preferences with respect to certain specific circumstances or situations.

No answer given to this question.

Other Instructions

I understand that, in certain jurisdictions, if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, medical treatment providers may refuse to follow my directives and provide life-sustaining treatment including artificially administered nutrition and hydration, as well as CPR and other resuscitation measures. Unless I have stated otherwise somewhere else in this uADD™, I understand that my healthcare agent may reconsider my medical treatment choices expressed above in light of my other instructions contained elsewhere in this uADD™ or new medical information.

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Part 3 Decisions on Organ Donation and Autopsy

Consent to Donate

No answer given to this question.

Autopsy

No answer given to this question.

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Part 4 My Thoughts

MyDirectives® offers people a list of optional questions that can be answered by typing text in a text box or by uploading a video or audio file for each question. Only those questions answered by tst-Lisa tst-Vidall appear here. If this part of the uADD™ is blank, then tst-Lisa tst-Vidall has not answered any of the My Thoughts questions. For a complete list of questions in My Thoughts, please visit www.MyDirectives.com.

No answer given to this question.

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Part 5 Making the uADD™ Legal

I am emotionally and mentally competent to make this uADD. I understand the purpose and effect of this uADD, I agree with everything that is written in this uADD, and I have made this uADD knowingly, willingly and after careful deliberation.

Signature (or my signature signed by the person named below) Date

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Universal Advance Digital Directive (uADD™)

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Individual Signature:

I am emotionally and mentally competent. I understand the purpose and effect of this advance care plan, I agree with everything written in this document, and I have made this document knowingly, willingly and after careful deliberation.

Signature _____ Date _____

I cannot sign my name, so I have asked the person indicated below to sign for me:

Signature (or my signature signed by the person named below) _____ Printed Name _____ Date _____

Statement of Witnesses

I declare that the person who signed this advance care plan, or who asked another to sign on his/her behalf, is the individual identified in the document. I believe this person to be of sound mind and at least 18 years of age. I personally witnessed the individual sign this document or ask the person indicated to do so, or I received adequate proof of identity, and I believe he/she did so voluntarily. By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not related to the person signing this document by blood, marriage or adoption.
- Not a healthcare agent appointed by the person signing this document.
- Not directly financially responsible for that person's healthcare.
- Not a healthcare provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain), officer, director, or partner of a healthcare provider (or any parent organization of such healthcare provider) directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

Witness Info:

Signature _____ Date _____

Printed Name _____ Phone _____

Address (Street, City, State, Zip) _____

Email _____

Electronically signed: unsigned

Document Version:

MyDirectives®

Universal Advance Digital Directive (uADD™)

tst-Lisa tst-Vidall

uADD/MyDirectives Digital Advance Care Plan

Electronically signed: unsigned

Document Version:

I am emotionally and mentally competent. I understand the purpose and effect of this advance care plan, I agree with everything written in this document, and I have made this document knowingly, willingly and after careful deliberation.

Signature (or my signature signed by the person named below) Date

I cannot sign my name, so I have asked the person indicated below to sign for me:

Signature (if signed on behalf of) Printed Name Date

Instructions for notary

Residents of certain jurisdictions may have their advance care plan signed by a notary public registered in their jurisdiction instead of having two witnesses.

Notary Public

On_____ (date), _____tst-Lisa tst-Vidall_____ (name) acknowledged in my presence or by sufficient electronic means his/her signature on this document or acknowledged he/she authorized the person signing this document to sign on his/her behalf. I am not named as a healthcare agent or alternate healthcare agent in this document.

(Notary Stamp)

Signature of Notary

Email Address

My commission expires on: _____