Advance Directive

MEDICAL POWER OF ATTORNEY

A medical power of attorney allows you the right to name someone else to make health care decisions on your behalf.

I choose to: (initial and check) (choose one)

- [ ] Have a medical power of attorney.
- [ ] Not have a medical power of attorney. Part I of this form is intentionally left blank.

A. PRINCIPAL. I, _____, with a mailing address of _____, Zip Code: _____ ____ hereby designate:
B. AGENT. _____, with a mailing address of _____, Zip Code: _____. AGENT'S TELEPHONE (CELL): _____
C. ALTERNATE AGENT. If my Agent is unable or unwilling to serve or make a decision in a timely manner, I select _____, with a mailing address of _____, to act as my alternate agent. ALTERNATE AGENT'S TELEPHONE: _____

I intend for my Agent to receive any and all of my health records and information as if I were the one requesting such information.

LIVING WILL

A living will allows a principal to select end-of-life treatment options in the chance of incapacitation with no viable cure.

I choose to: (initial and check) (choose one)

- [ ] Have a living will.
- [ ] Not have a living will. Part II of this form is intentionally left blank.

A. PRINCIPAL. I, _____, with a mailing address of _____, with the last four (4) digits of my social security number (SSN) being _____ ("Principal") desire to advise my doctors and medical providers of my wishes for my health care in the event I am not able to communicate my wishes.

B. LIFE SUPPORT.

I desire that my doctor make a concerted effort to return me to an acceptable quality of life using then available treatments and therapies. However, if my quality of life becomes unacceptable as I have defined below, and my doctors have determined that my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

An unacceptable quality of life means (initial and check all that apply):

- [ ] Chronic coma or persistent vegetative state
- [ ] No longer able to communicate my needs
- [ ] No longer able to recognize family or friends
- [ ] Total dependence on others for daily care
- [ ] Other: _____.

(initial and check) (choose one)

- [ ] Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).
- [ ] If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

C. CERTAIN LIFE-SUSTAINING TREATMENT.

Some people do not wish to have certain life-sustaining treatments under any circumstance, even if recovery is a possibility. Check the treatments below, if any, that you do not wish to have under any circumstances:

(initial and check) (choose one)

- [ ] Cardiopulmonary Resuscitation (CPR)
- [ ] Ventilation (breathing machine)
- [ ] Feeding tube
- [ ] Dialysis
- [ ] Other: _____.

D. END OF LIFE WISHES. (hospice care, funeral arrangements, etc.):

When I am near death, it is important to me that: _____

I have signed this document on _____.

- Principal's Signature: _____
- Print Name: _____

WITNESS 1

- Signature: _____ Date: _____
- Print Name: _____

WITNESS 2

- Signature: _____ Date: _____
- Print Name: _____