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, [NAME], with a mailing address of [ADDRESS], City of [CITY], State of [STATE], Zip Code: [ZIP] hereby designate:

B. AGENT. [NAME], with a mailing address of [ADDRESS], City of [CITY], State of [STATE], Zip Code: [ZIP]. AGENT'S TELEPHONE (CELL): [PHONE]

C. ALTERNATE AGENT. If my Agent is unable or unwilling to serve or make a decision in a timely manner, I select [NAME], with a mailing address of [ADDRESS], City of [CITY], State of [STATE], to act as my alternate agent. ALTERNATE AGENT'S TELEPHONE: [PHONE]

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, [NAME], with a mailing address of [ADDRESS], City of [CITY], County of [COUNTY], State of [STATE], with the last four (4) digits of my social security number (SSN) being SSN 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determined that my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.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: [DESCRIBE].

(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: [DETAILS].

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

When I am near death, it is important to me that: [DETAILS]

I have signed this document on _____.

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

WITNESS 1

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

WITNESS 2

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