ADVANCE HEALTHCARE DIRECTIVE

State of _____

This document allows you to express your wishes regarding the medical care and treatments you want or don't want if you become unable to make decisions on your own. It is recommended that you provide a copy of this document to your doctor, family, and friends.

PART I . ADVANCE HEALTHCARE DECLARATION

I, _____[Full Name], being sound mind and legal age, freely and knowingly make this declaration to express my wishes for medical care if I am unable to communicate them myself. I request that my family, doctors, and anyone else involved in my care respect this declaration.

DEFINITIONS

- **Artificial nutrition and hydration** refers to food, supplements, or fluids provided through IV therapy or a feeding tube.
- **Life-sustaining treatment** means any procedure, treatment, or medication that keeps a person alive when they would otherwise die. Examples include antibiotics, artificial respiration, CPR, dialysis, transfusions, and the use of a ventilator.
- **A permanent unconscious state** is a complete loss of consciousness from which recovery is unlikely in the near future. Examples include a persistent vegetative state and irreversible coma.

- **A terminal condition** is an irreversible illness that will likely lead to death or an unconscious state from which recovery is improbable in the near future.

MEDICAL POWER OF ATTORNEY

I choose to [Please check one]:

☐ Appoint a medical power of attorney

☐ Not appoint a medical power of attorney. Part III of this form is intentionally left blank.

A. Principal:

I, _____, residing at _____ in the city of _____, state of _____, with a zip code of _____(“Principal), designate:

B. Agent:

_____, with a mailing address of _____, city of _____, state of _____, zip code: _____ (“Agent”).

Agents Phone (Cell): (_____) - _____ _____

I designate the person named above as my Agent to make decisions regarding my healthcare (including mental healthcare) on my behalf. This includes giving or refusing consent for medical and surgical treatments, hospitalizations, and any related care. This power of attorney becomes effective if I am unable to communicate my healthcare wishes. Any decision my Agent makes

while I am incapacitated or if my survival is uncertain will be binding on my heirs, beneficiaries, and personal representatives.

C. Alternate Agent:

If my Agent is unable or unwilling to serve, I choose _____, residing at _____, city of _____, state of _____, as my alternate Agent ("Alternate Agent").

Alternate Agent's Phone (Cell): (_____) - _____ _____

I authorize my Agent to access all my health information as if I were requesting it myself. This includes any details governed by the Health Insurance Portability and Accountability Act (HIPAA), 42 USC 1420D, and 45 CFR 160-164.

PART II. LIVING WILL

A living will allows me, as the Principal, to state my preferences for end-of-life treatment in case I am unable to communicate and there is no chance of recovery.

I choose to: (Please check one)

- ☐ Create a living will.
- ☐ Do not create a living will. Part II of this form will intentionally be left blank.

A. Principal:

I, _____, residing at _____, in the city of _____, county of _____, state of _____, with the last four digits of my social security number being _____, ("Principal"), wish to communicate my healthcare preferences if I am unable to do so myself.

B. Life Support:

I would like my doctor to make every effort to restore me to a quality of life I find acceptable, using any available treatments. However, if my quality of life falls below acceptable standards (defined below) and my condition is irreversible, I request that life-extending treatments be stopped.

Unacceptable quality of life (initial and check all that apply):

- ☐ _____ Permanent coma or vegetative state
- ☐ _____ Inability to communicate my needs
- ☐ _____ Inability to recognize family or friends
- ☐ _____ Complete dependence on others for daily care
- ☐ _____ Other: _____

Initial and check one option only:

- ☐ _____ Even with the above conditions, I still wish to receive food and water via tube or IV.
- ☐ If the above conditions apply, I do not wish to receive food and water via tube or IV.

C. Specific Life-Sustaining Treatments:

Some people may not want specific life-sustaining treatments in any case, even if recovery is possible. Please check any treatments below that you do not wish to receive under any circumstances:

- ☐ _____ Cardiopulmonary Resuscitation (CPR)
- ☐ _____ Ventilator (breathing machine)
- ☐ _____ Feeding tube
- ☐ _____ Dialysis
- ☐ _____ Other: _____

D. End-of-Life Preferences:

When I am near the end of life, it is important to me that:

_____

_____

_____

Signed on this _____ day of _____, _____[Year].

Principal's Signature: _____

Print Name: _____

Depending on state laws, you may need two (2) witnesses or a notary public to complete this form.

WITNESSES / NOTARY ACKNOWLEDGEMENT

On the date above, I affirm that the person is known to me, appears to be sound of mind, and has signed the document voluntarily. I am at least 18 years old, not related by blood, marriage, or adoption, and not named as an Agent in this document. To my knowledge, I am not a beneficiary of this person's will or any other legal claims and have no interest in their estate. I am not involved in their healthcare.

Witness 1

Signature: _____ Date: _____

Print Name: _____

Witness 2

Signature: _____ Date: _____

Print Name: _____

Notary Certification

State of _____

County of _____

Signed and sworn to me on the _____ day of _____, _____[Year]

As an authorized official in this county and state, I certify that _____, the Principal whose name is signed above, acknowledged before me that they understood the contents of this document and signed it willingly on the specified date.

Notary Public Signature: _____

Printed Name: _____

My commission expires: _____

(Notary Seal)