

Advanced Directive Form

I, _____, being of sound mind and legal capacity, hereby execute this Advanced Directive to provide guidance regarding my medical treatment preferences in the event that I am unable to make decisions for myself.

My Personal Information		
Name (First, Middle, Last):	DOB:	
Street Address:		
City:	State:	Zip:
Email:	Phone #:	

I appoint _____, as my healthcare agent to make all healthcare and medical decisions on my behalf, if I am unable to do so. If my designated healthcare agent is unable or unwilling to act on my behalf, I appoint _____, as my alternative healthcare agent.

Healthcare Agent #1		
Name (First, Middle, Last):	DOB:	
Street Address:		
City:	State:	Zip:
Email:	Phone #:	

Healthcare Agent #2		
Name (First, Middle, Last):	DOB:	
Street Address:		
City:	State:	Zip:
Email:	Phone #:	

When Agents Authority Becomes Effective: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

Agent's Obligations: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

Declaration of Desires: I express my desires regarding medical treatment as follows:

A. Life-Sustaining Treatment:

I request that all medically available means be used to prolong my life, including but not limited to, artificial respiration, artificial nutrition, and hydration.

OR

I do not want my life to be artificially prolonged, and I request that only treatment necessary for my comfort be provided.

B. Do-Not-Resuscitate (DNR) Order:

I request that no cardiopulmonary resuscitation (CPR) or other resuscitative measures be used if my heart or breathing stops.

OR

I do not have a DNR order and wish for CPR and resuscitative measures to be used.

C. Organ Donation:

I wish to donate my organs for transplantation or medical research, as specified in a separate organ donation document or as allowed by applicable laws.

Palliative Care and Comfort Measures:

I request palliative care to manage pain and provide comfort in the event of a terminal illness or irreversible condition.

Specific Medical Treatment Instructions and Preferences: Please include any specific medical treatment instructions or preferences you may have, such as religious or cultural considerations, pain management, or other medical procedures not mentioned above.

Advance Care Planning Discussion:

I have discussed my advanced directive and medical preferences with my healthcare agent, family members, and healthcare providers. I declare that I am signing this Advanced Directive willingly and without any coercion. I have read and understood its contents, and I am aware of the consequences of my choices.

Print Name

Date

Signature

Address

Statement of Witness: I declare under penalty of perjury that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence. That the individual signed or acknowledged this advance directive in my presence. That the individual appears to be of sound mind and under no duress, fraud, or undue influence.

Witness #1:

Print Name

Date

Signature

Address

Witness #2:

Print Name

Date

Signature

Address