ADVANCE DIRECTIVE FOR HEALTH CARE (LIVING WILL)

Instructions: Have your healthcare provider assist you when developing your Advance Directive. Keep the original at home where it can easily be found. Give copies of the completed form to your doctor(s), your family, your Medical Representative, and anyone else who is likely to be contacted in a medical emergency. Review your Advance Directive form from time to time and make any needed changes. Initial and date the form every time you review or change it. Make sure you inform others of the changes you make

To my Family, Doctors and others concerned with my care:

I,____ , being of sound mind, hereby declare and make known my instructions and wishes for future health care in the event that, for reasons due to physical or mental incapacity, I am unable to participate in decisions regarding my care. I understand that the law gives me the right to accept or refuse treatment. Therefore, I expect my family, doctors and everyone concerned with my care to regard themselves as legally bound to follow these instructions. If they do, everyone will be free of any legal liability for having followed my directions.

Medical Representative (Proxy) Designations(s): If I become unable to communicate my wishes due to illness, injury, or unconsciousness, the following individuals are hereby appointed and may make decisions on my behalf, and the hospital, its employees and physicians may rely and follow the instructions of these representatives.

Name Relationship Telephone

Street City State Zip

If my Medical Representative is unable to act, then I appoint as alternate:

Name Relationship Telephone

Street City State Zip

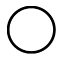
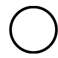
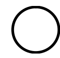
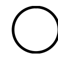
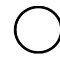
Please initial the statement or statements with which you agree. (Select #1 or #2, but not both.)

________ 1. I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition.

________ 2. If I experience extreme mental or physical deterioration such that there is no reasonable expectation of recovery or regaining a meaningful quality of life, then life-prolonging measures should not be initiated; or if they have been, they should be discontinued. Those life-sustaining procedures or treatments that may be withheld or withdrawn include but are not limited to

☐ Cardiac resuscitation (CPR) ☐ Mechanical ventilation ☐ Major surgery
☐ Dialysis ☐ Artificially administered fluids and nutrition
☐ Use of blood products ☐ Other (Please specify) ______________________________________

________ 3. I direct that I be given appropriate medical care to alleviate pain and keep me comfortable.

C. Additional comments or instructions:

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After death, it may be possible to transplant human organs or tissues in order to save or improve the lives of others.

☐ I wish to be an organ donor:
☐ I wish to be a tissue donor:
☐ I am not interested in being an organ and/or tissue donor
☐ I have not fully considered organ and/or tissue donation and empower my family
or Medical Representative to use their discretion in this matter

____ ________________________

Signature Date Time

Address____ City:___________________ State:______ Zip_______

Date of Birth:_______________________________

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Witness Telephone Date

____

Witness Telephone Date