**ADVANCE HEALTH CARE DIRECTIVE**

Directive made this \_\_ \_\_ day of \_\_\_\_\_ \_\_\_\_, Year

**Durable Power of Attorney for Health Care**

I understand that my wishes as expressed in my advance directive may not cover all possible aspects of my care if I become incapacitated. Consequently, there is a possibility that someone else will have to consent or refuse certain medical interventions on my behalf if I am unable to do so.

Therefore, I, \_\_\_\_\_ (your full name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as principal, designate the person(s) listed below as my attorney-in-fact for all health care decisions.

First Choice:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the above person is unable or unwilling to serve, I designate:

Second Choice:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When I still possess the full capacity to make my own healthcare decisions, I willfully and voluntarily make known my desire that my life should be artificially prolonged under the circumstances below, and do hereby declare that:

(a) If I should be diagnosed, in writing, to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness that would, within reasonable medical judgment, cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or persistent vegetative state.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

(c) If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (initial and check **one** in each category):

Nutrition:

\_\_\_\_\_\_\_  I **DO** want to have artificially provided nutrition.

\_\_\_\_\_\_\_  I **DO NOT** want to have artificially provided nutrition.

Hydration:

\_\_\_\_\_\_\_  I **DO** want to have artificially provided hydration.

\_\_\_\_\_\_\_  I **DO NOT** want to have artificially provided hydration.

(d) If I have been diagnosed as pregnant, and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy*.* (note: add additional instructions here, and/or make clear if a pregnancy would impact your directives)

(e) I understand the full weight of this directive, and I am emotionally and mentally capable to make the health care decisions contained in this directive.

(f) I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with state law or federal constitutional law to be legally valid.

Signed: \_\_\_(your full name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_(your full address)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Each of us personally knows the person (the "declarer") signing her name above, and we believe that person to be of sound mind. The signature above was made in the presence of both of us. Neither of us is related to the declarer by blood or marriage nor is either of us, to our knowledge, entitled to any portion of the declarer's estate upon the declarer's death, nor does either of us have any claim against any portion of the estate at this time. Neither of us is the attending physician, an employee of that physician, or an employee of a healthcare facility in which the declarer is a patient.

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| **Witness 1**  Signature:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Witness 2**  Signature:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |