

HEALTH CARE DIRECTIVE

TO MY FAMILY, MY DOCTOR, AND ALL THOSE CONCERNED WITH MY CARE:

I, (print name and address) _____

being sixteen (16) years of age or older and capable of making decisions regarding my health care, voluntarily provide these instructions and directions, to be followed at such time in the future as I lose the capacity to make or communicate decisions regarding my health care.

It is my wish that my physicians, caregivers, family and friends to the greatest extent possible respect this directive. I realize that unpredictable situations may arise and that parts of my directive may be open to interpretation. I direct those deciding on my behalf to be guided by my wishes contained herein, but to decide as any reasonable person in my circumstance would decide if my wish is unclear.

I have discussed this directive with the following people and provided each of them with a copy. I understand that it is my responsibility to ensure that all copies are reviewed on a regular basis, amended in identical fashion when necessary, or revoked uniformly if I so choose.

Copy 1: _____

Copy 2: _____

Copy 3: _____

Copy 4: _____

Copy 5: _____

PART 1 – MY HEALTH CARE WISHES

(You should cross out and initial any unacceptable sections or sentences. A space is provided at the end of this part for you to add any other wishes. You can use more paper if necessary.)

1. In an emergency situation, if I lose the capacity to make or communicate decisions, but *my doctors believe it is likely or reasonably possible* that I will recover that capacity with appropriate treatment, I request that all standard medical care be provided. This is my wish regardless of whether I have another illness, incurable or otherwise.

2. If I suffer an illness or condition normally viewed as *temporary* for people in my situation, and it removes my capacity to make or communicate health care decisions, I wish to receive standard medical care, such that my decision-making capacities may be restored.

3. If I have a physical or mental illness that will cause or contribute to my death and from which there is *no reasonable expectation* of my recovery or significant improvement, and this illness causes me to permanently lose the capacity to make or communicate decisions, I direct that I be allowed to die and not be kept alive by:
 - a) medical interventions such as (but not limited to) artificial ventilation or respiration, cardiopulmonary resuscitation, medications designed to prolong death or sustain life, antibiotics, renal dialysis, or any other intervention normally employed to cure illness or sustain life during temporary illness, or
 - b) food, water, or other nutrients administered by any means by another person, or
 - c) surgery, unless suggested purely as a means of bringing me comfort or relieving otherwise unrelievable pain, or
 - d) any other medical intervention normally viewed as curative or life-sustaining, or
 - e) _____

I do direct, however, that medications and other medical interventions be administered to me to alleviate my pain and suffering to the greatest extent possible, even though this may hasten the moment of my death. I further request the following measures:

In the following lines, I describe my personal philosophy, values and beliefs as well as other health care wishes, to be used as guidance for those deciding on my behalf. *(Use more paper if necessary.)*

PART 2 – MY PROXY DIRECTIVE

I appoint the following person(s) to be my health care proxy or proxies. (*A proxy must be 18 years of age or older and capable of making health care decisions. A proxy may be under 18 years of age if he or she is the spouse of the person making this directive.*) I direct my proxy to make health care decisions on my behalf should I become unable to make or communicate my own decisions, and to be guided in so doing by the wishes I have described in PART 1 of this document and in any discussions we may have had. My recorded wishes shall take priority over any unrecorded wishes with which they conflict.

I recognize that there are degrees of ability to make and/or communicate health care decisions and I direct my proxy to decide on my behalf if my health care providers believe I am unable to decide. (I shall continue to decide on my own until such a time occurs.) I also realize that my life expectancy, prognosis or accurate wishes may be unclear. In this event, I direct my proxy to carefully consider the opinions of my health care providers whenever possible before making decisions on my behalf.

PROXY 1: Name: _____

Address: _____

Phone: _____

PROXY 2: Name: _____

Address: _____

Phone: _____

PROXY 3: Name: _____

Address: _____

Phone: _____

If I have named more than one proxy, they shall act (*check one*): jointly [] in the order listed []. If acting jointly, my proxies shall have authority to decide in the order listed when disagreements arise. If acting in the order listed, they shall make decisions according to their availability and/or willingness to decide.

I do **not** name _____

_____ as proxy decision-maker(s) because it would be unfair to do so, since we have different beliefs in regard to the matters set out in this health care directive.

PART 3 – SIGNATURES

Signature of the maker of this directive: _____

Address: _____

Date: _____

(A substitute may sign on your behalf in your presence if you are unable to sign. This substitute signer cannot be one of your proxies or the proxy's spouse. If you use a substitute signer, a witness must also sign. The witness cannot be one of your proxies or the proxy's spouse.)

Substitute signer, if any: _____

Address: _____

Date: _____

Witness's Declaration:

I declare that the substitute signer signed this document at the request of and in the presence of the maker. Neither the substitute signer nor I am appointed as health care proxy by this document; neither the substitute signer nor I am the spouse of the health care proxy. I attest and subscribe this health care directive in the presence of the maker.

Signature of witness: _____

Address: _____

Phone: _____

Date: _____