APPOINTMENT OF HEALTHCARE AGENT

# ADVANCE DIRECTIVE - PART A
# APPOINTMENT OF HEALTH CARE AGENT

*(Optional Form)*

**INSTRUCTIONS**

*If you decide to appoint a healthcare agent, complete Part A (p. 1-2) and cross through any items in the form that you do not want to apply.Cross through this whole part of the form if you do not want to appoint a health care agent to make health care decisions for you.*

**PRINT YOUR NAME AND ADDRESS**

I, ___________________________________________________________
residing at
_____________________________________________________________

**PRINT THE NAME ADDRESS, AND TELEPHONE NUMBER OF YOUR HEALTHCARE AGENT (At least 18 years old)**

appoint the following individual as my agent to make health care decisions for me:
_____________________________________________________________

_____________________________________________________________

**(Full Name, Address and Telephone Number of Agent)**

**PRINT THE NAME ADDRESS, AND TELEPHONE NUMBER OF YOUR ALTERNATE HEALTHCARE AGENT (At least 18 years old)**

Optional: If this agent is unavailable or is unable or unwilling to act as my agent, then I appoint the following person to act in this capacity:
_______________________________________________________________

_______________________________________________________________

**(Full Name, Address and Telephone Number of Back-up Agent)**

2. My agent has full power and authority to make health care decisions for me, including the power to:

A. Request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and consent to disclosure of this information;
B. Employ and discharge my health care providers;
C. Authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult home, or other medical care facility; and
D. Consent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life-sustaining procedures.

**APPOINTMENT OF HEALTHCARE AGENT**

# APPOINTMENT OF HEALTHCARE AGENT (continued)

**LIST RESTRICTIONS TO YOUR AGENT'S POWER (IF ANY)**

3. The authority of my agent is subject to the following provisions and limitations:____________________________________________________________
_______________________________________________________________

**ADD MODIFICATIONS TO APPLY DURING PREGNANCY(OPTIONAL)**

4. If I am pregnant, my agent shall follow these specific instructions:_________________________________________________________
_______________________________________________________________

**INITIAL THE OPTION THAT REFLECTS YOUR WISHES**

5. My agent's authority becomes operative *(initial only the one option that applies):*

_________________When my attending physician and a second physician determine that I am incapable of making an informed decision regarding my health care, or

_________________When this document is signed.

6. My agent is to make health care decisions for me based on the health care instructions I give in this document and on my wishes as otherwise known to my agent. If my wishes are unknown or unclear, my agent is to make health care decisions for me in accordance with my best interest, to be determined by my agent after considering the benefits, burdens, and risks that might result from a given treatment or course of treatment, or from the withholding or withdrawa1 of a treatment or course of treatment.

7. My agent shall not be liable for the costs of care based solely on this authorization.

**SIGN AND DATE THE DOCUMENT HERE**

By signing below, I indicate that I am emotionally and mentally competent to make this appointment of a health care agent and that I understand its purpose and effect.

___________________________Date

__________________________________________ Signature of Declarant

**WITNESSING PROCEDURE**

The declarant signed or acknowledged signing this appointment of a health care agent in my presence and, based upon my personal observation, appears to be a competent individual. *At least one of us is not knowingly entitled to any portion of the estate of the declarant or knowingly entitles to any financial benefit by reason of the death of the declarant. Neither of us is the healthcare agent, or alternate agent, for the declarant.*

**SIGNATURES AND ADDRESSES OF TWO WITNESSES (At least 18 years old)**

| ______________________________ | ______________________________ |
| --- | --- |
| (Witness) | (Witness) |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |

SIGNATURES AND ADDRESSES OF TWO WITNESSES

HEALTHCARE INSTRUCTIONS

## ADVANCE DIRECTIVE - PART B HEALTH CARE INSTRUCTIONS

(Optional Form)

**FOR EACH QUESTION, INITIAL THE OPTION THAT REFLECTS YOUR WISHES**

Complete this form to create written healthcare instructions (p. 3 & 4). **Initial those statements you want to be included in the document and cross through those statements that do not apply.** Cross through this whole part of the form if you do not want to give health care instructions.

**If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions as stated below.**

**TERMINAL CONDITION**

1.If I am close to death due to injury, disease or illness, and my doctors believe there is no reasonable hope of recovery, even with life sustaining procedures, I direct that my life (initial one):
____ Not be extended by any medical treatment except comfort care and medication to alleviate pain, even if the pain medication would shorten my remaining life.
____ Not be extended by any life sustaining procedures (such as tube feeding, ventilators and CPR).
____ Not be extended by life sustaining procedures, except that if I can not take food or liquids by mouth, I wish to be tube fed.
____ Be extended by all available medical means in accordance with accepted healthcare standards.

**PERSISTENT VEGETATIVE STATE**

If I am permanently unconscious and my doctors believe that there is no reasonable hope of recovery, I direct that my life (initial one):
____ Not be extended by any medical treatment except comfort care and medication to alleviate pain, even if the pain medication would shorten my remaining life.
____ Not be extended by any life sustaining procedures (such as tube feeding, ventilators and CPR).
____ Not be extended by life sustaining procedures, except that if I can not take food or liquids by mouth, I wish to be tube fed.
____ Be extended by all available medical means in accordance with accepted healthcare standards.

**END-STAGE CONDITION**

If I have become so sick or seriously injured from a progressive condition that I am unable to make medical decisions and I am completely dependent on others with no reasonable hope of recovery, I direct that my life (initial one):
____ Not be extended by any medical treatment except comfort care and medication to alleviate pain, even if the pain medication would shorten my remaining life.
____ Not be extended by any life sustaining procedures (such as tube feeding, ventilators and CPR).
____ Not be extended by life sustaining procedures, except that if I can not take food or liquids by mouth, I wish to be tube fed.
____ Be extended by all available medical means in accordance with accepted healthcare standards.

HEALTHCARE INSTRUCTIONS

## HEALTHCARE INSTRUCTIONS (continued)

**ADD MODIFICATIONS TO APPLY DURING PREGNANCY (OPTIONAL)**

4. If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:_________________________________________________________________

_________________________________________________________________

**ADD FURTHER PERSONAL INSTRUCTIONS (IF ANY)**

5. I further direct (in the following space, indicate any other instructions regarding receipt or nonreceipt of any health care):

**ORGAN DONATION (OPTIONAL)**

6. I provide the following instructions regarding donation of my organs and tissues for transplant, medical study or education. If I choose to be a donor, I want artificial heart/lung support devices continued only until such time as organ suitability is confirmed and organ recovery has taken place (initial one):

_____ I want to donate all my organs and tissues.
_____ I do not wish to donate any of my organs and tissues.
_____ I wish to donate only these organs and tissues:
_____________________________________________________________
_____________________________________________________________

**SIGN AND DATE THE DOCUMENT HERE**

By signing below, I indicate that I am emotionally and mentally competent to write these healthcare instructions and that I understand the purpose and effect of this document.

_________________________(Date)

__________________________________________(Signature of Declarant)

**WITNESSING PROCEDURE**

The declarant signed or acknowledged signing this appointment of a health care agent in my presence and, based upon my personal observation, appears to be a competent individual. *At least one of us is not knowingly entitled to any portion of the estate of the declarant or knowingly entitles to any financial benefit by reason of the death of the declarant. Neither of us is the healthcare agent, or alternate agent, for the declarant.*

**SIGNATURES AND ADDRESSES OF TWO WITNESSES ( At least 18 years old)**

| | |
|---|---|
| ___________________________ | ___________________________ |
| (Witness) | (Witness) |
| ___________________________ | ___________________________ |
| ___________________________ | ___________________________ |
| ___________________________ | ___________________________ |

*(Signatures and Addresses of Two Witnesses)*