Store Data | Retrieve Data | Clear Form | Exit

FORM I LIVING WILL

(Optional Form)

If I am not able to make an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below. (Initial those statements you wish to be included in the document and cross through those statements which do not apply.)

a. If my death from a terminal condition is imminent and even if life-sustaining procedures are used there is no reasonable expectation of my recovery—

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that, if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

_____ I direct that, even in a terminal condition, I be given all available medical treatment in accordance with accepted health care standards.

b. If I am in a persistent vegetative state, that is if I am not conscious and am not aware of my environment nor able to interact with others, and there is no reasonable expectation of my recovery within a medically appropriate period—

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take in food by mouth, I wish to receive nutrition and hydration artificially.

_____ I direct that I be given all available medical treatment in accordance with accepted health care standards.

c. If I am pregnant my agent shall follow these specific instructions:

By signing below, I indicate that I am emotionally and mentally competent to make this living will and that I understand its purpose and effect.

_____ _____

(Date) (Signature of Declarant)

The declarant signed or acknowledged signing this living will in my presence and based upon my personal observation the declarant appears to be a competent individual.

_____ _____

(Witness) (Witness)

FORM II ADVANCE DIRECTIVE

Part A—Appointment of Health Care Agent (Optional Form)

(Cross through if you do not want to appoint a health care agent to make health care decisions for you. If you do want to appoint an agent, cross through any items in the form that you do not want to apply.)

(1) I, , residing at
appoint the following individual as my agent to make health care decisions for me

(Full Name, Address, and Telephone Number)

[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)]

(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.

(3) The authority of my agent is subject to the following provisions and limitations:

(4) My agent's authority becomes operative (initial the 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.

(5) 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 withdrawal of a treatment or course of treatment.

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

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.

_____ _____
(Witness) (Witness)

Part B—Advance Medical Directive Health Care Instructions
(Optional Form)

(Cross through if you do not want to complete this portion of the form. If you do want to complete this portion of the form, initial those statements you want to be included in the document and cross through those statements that do not apply.)
If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below. (Initial all those that apply.)
(1) If my death from a terminal condition is imminent and even if life-sustaining procedures are used there is no reasonable expectation of my recovery —
_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.
_____ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.
(2) If I am in a persistent vegetative state, that is, if I am not conscious and am not aware of my environment or able to interact with others, and there is no reasonable expectation of my recovery —
_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.
_____ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.
(3) If I have an end-stage condition, that is a condition caused by injury, disease, or illness, as a result of which I have suffered severe and permanent deterioration indicated by incompetency and complete physical dependency and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective —
_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.
_____ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.
(4) If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

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

By signing below, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand the purpose and effect of this document.

_____ _____
(Date) (Signature of Declarant)

The declarant signed or acknowledged signing the foregoing advance directive in my presence and based upon personal observation appears to be a competent individual.

_____ _____
(Witness) (Witness)

