Advance Health Care Directive

I _____of (Full address): _____

_____ _____am able to make an informed decision regarding my health care, I direct that my instructions and wishes as stated in this document be followed.

1. EFFECTIVITY. This document shall become effective immediately.

2. TERMINAL CONDITION. If I have a "terminal condition", I direct that my life not be extended by life sustaining procedures; such procedures shall be withheld or withdrawn.

3. COMA. If I am in a "permanent coma", I direct that my life not be extended by life-sustaining procedures; such procedures shall be withheld or withdrawn.

4. LIFE SUSTAINING PROCEDURES. By the use of the term "life sustaining procedures", I mean any procedure, treatment, intervention, or other measure that has the primary effect of prolonging my life and is not necessary to provide for my comfort or freedom from pain.

5. ARTIFICIAL NUTRITION / HYDRATION. I authorize my Agent to determine whether artificial nutrition or hydration should be withheld or withdrawn.

6. HOLD HARMLESS. All persons or entities who in good faith endeavor to carry out the terms and provisions of this document shall not be liable to me, my estate, or my heirs for any damages or claims arising because of their action or inaction based on this document, and my estate shall defend and indemnify them, except for willful misconduct or gross negligence.

7. SEVERABILITY. If any provision in this document is held to be invalid, such invalidity shall not affect the other provisions which can be given effect without the invalid provision, and thus the directions in this document are severable.

I have read and understand the contents of this document. I am emotionally and mentally competent to make this declaration.

Date: _____

Declarant's Signature: _____

Print Full Name: _____

Address: _____

City / State / Zip: _____County: _____

Living Will

Declaration made this_____day of_____(yr.)_____
I_____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

If at any time I have a terminal condition and if my attending or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition or state, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

If any provision in this document is held to be invalid, such invalidity shall not affect the other provisions, which can be given effect without the invalid provision, and to this end the directions in this document are severable.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Declarant Signature: _____

Print Full Name: _____

Address: _____

City / State / Zip: _____

Witness Signature: _____

Print Full Name: _____

Address: _____

City / State / Zip: _____

Witness Signature: _____

Print Full Name: _____

Address: _____

City / State / Zip: _____

Designation of Health Care Surrogate

1. DESIGNATION OF HEALTH CARE SURROGATE**.** In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my Surrogate for health care decisions:

Surrogate Name: _____

Print Full Name: _____

Address: _____

City / State / Zip:_____

Relation, If any:_____ Home Phone:_____

2. AUTHORITY OF SURROGATE. I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; to have access to my records necessary to make decisions or apply for benefits; and to authorize my admission to or transfer from a health care facility.

3. STATEMENT OF DESIRES CONCERNING LIFE-PROLONGING CARE, TREATMENT, SERVICES AND PROCEDURES: I specifically direct my Surrogate to follow any "living will" executed by me.

4. STATEMENT OF DESIRES CONCERNING NUTRITION AND FLUIDS.
Artificially provided nutrition or fluids provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, shall NOT be among the "life-prolonging procedures" that may be withheld or withdrawn under the conditions given above.

5. SPECIAL PROVISIONS. (Unless the Principal expressly delegates authority to the Surrogate, a Surrogate may not consent to: (1) abortion, sterilization, electroshock therapy, psychosurgery, experimental treatments that have not been approved by a federally approved institutional review board in accordance with *45* C.F.R., Part 46, 21 C.F.R., Part 56, or voluntary admission to a mental health facility; (2) withholding or withdrawing life-prolonging procedures from a pregnant patient prior to viability as defined in Section 390.001(5).)

SPECIAL PROVISIONS REGARDING MY HEALTH CARE (For example, describe your wishes regarding any treatment you desire or do not desire, or admission to a residential care facility

_____

_____

_____

_____

_____

6. AUTOPSY, ANATOMICAL GIFTS, DISPOSITION OF REMAINS**.** I authorize my Surrogate, to the extent permitted by law, to make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains.

7. DESIGNATION OF ALTERNATE SURROGATE(S). If my Surrogate is unwilling or unable to perform his/her duties, I wish to designate as my Alternate Surrogate:

Designation of Health Care Surrogate

First Alternative Surrogate: _____

Print Full Name: _____

Address: _____

City / State / Zip: _____

Relation, If any: _____Home Phone:_____

8. REVOCATION**.** I revoke any prior Designation of Health Care Surrogate. This Designation may be revoked at any time by:

(a) A signed, dated writing;
(b) Physical cancellation or destruction of the designation by myself or another in my presence and at my direction;
(c) An oral expression of my intent to revoke; or (d) Executing a subsequent directive.

9. HOLD HARMLESS. All persons or entities who in good faith endeavor to carry out the terms and provisions of this document shall not be liable to me, my estate, my heirs or assigns for any damages or claims arising because of their action or inaction based on this document, and my estate shall defend and indemnify them.

10. SEVERABILITY. If any provision of this document is held to be invalid, such invalidity shall not affect the other provisions which can be given effect without the invalid provision, and to this end the directions in this document are severable.

11. STATEMENT OF INTENTIONS. It is my intent that this document be legally binding and effective. If the law does not recognize this document as legally binding and effective, it is my intent that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period in which I am unable to make such decisions.

YOU MUST DATE AND SIGN THIS DESIGNATION IN THE PRESENCE OF TWO WITNESSES)

I affirm that this Designation is not being made as a condition of treatment or admission to a health care facility. I have read and understand the contents of this document and the effect of this grant of powers to my Surrogate. I am emotionally and mentally competent to make this declaration

Signature: _____ This _____ day of _____, _____

Print Full Name: _____

Address: _____

City / State / Zip:_____

Witness Signature: _____Witness Signature: _____

Print Full Name: _____ Print Full Name: _____

Address: _____ Address:_____

City / State / Zip: _____ City / State / Zip:_____

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