

5307 Allum Rd., Unit B  
Houston TX 77045  
MedicalDirectives.net  
T/F: 866 -300-7388

Thank you for downloading the PDF-fillable form for your Medical Directive, Advance Medical Directive, or Medical Power of Attorney. The process is very straightforward:

1. Choose the subscription type you want and pay online. We use paypal for all credit card processing and NEVER store your Credit Card Information.
2. Download the form to your computer.
3. Fill it out on your computer and print it.
4. Take the filled-form to your favorite notary (or your witnesses) and have it notarized or witnessed.
5. Fax your paperwork to 866-300-7388. If you want to email it instead, please SCAN all to PDF utilizing 200 DPI scan settings, making 1 PDF file, and email to [forms@medicaldirectives.net](mailto:forms@medicaldirectives.net)
6. Your Retrieval Card is emailed out to you within 24 hours of receiving your medical directive. If you lose it or need another one, you can generate one easily on our web portal .

Here is the form for the state you selected. Please do not fax back any instruction sheets. We do not require a coversheet when you fax.

**PROXY DIRECTIVE--(Durable Power of Attorney for Health Care)  
Designation of Health Care Representative**

I understand that as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decision. In these circumstances, those caring for me will need direction and they will turn to someone who knows my values and health care wishes. By writing this durable power of attorney for health care I appoint a health care representative with the legal authority to make health care decisions on my behalf and to consult with my physician and others. I direct that this document become part of my permanent medical records.

**A) CHOOSING A HEALTH CARE REPRESENTATIVE:**

I, \_\_\_\_\_, hereby designate \_\_\_\_\_,  
of \_\_\_\_\_

\_\_\_\_\_  
(home address and telephone number of health care representative)

as my health care representative to make any and all health care decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining measures. I direct my representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear, my representative is authorized to make decisions in my best interest, based on what is known of my wishes.

This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations.

**B) ALTERNATE REPRESENTATIVES:** If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in the order of priority stated:

- |                        |                        |
|------------------------|------------------------|
| 1. name _____          | 2. name _____          |
| address _____          | address _____          |
| city _____ state _____ | city _____ state _____ |
| telephone _____        | telephone _____        |

**C) SPECIFIC DIRECTIONS: Please initial the statement below which best expresses your wishes.**

\_\_\_\_\_ My health care representative is authorized to direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion, be withheld or withdrawn.

\_\_\_\_\_ My health care representative does not have this authority, and I direct that artificially provided fluids and nutrition be provided to preserve my life, to the extent medically appropriate.

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(If you have any additional specific instructions concerning your care you may use the space below or attach an additional statement.)

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**D) COPIES:** The original or a copy of this document has been given to my health care representative and to the following:

1. name \_\_\_\_\_  
address \_\_\_\_\_  
city \_\_\_\_\_ state \_\_\_\_\_ telephone \_\_\_\_\_
2. name \_\_\_\_\_  
address \_\_\_\_\_  
city \_\_\_\_\_ state \_\_\_\_\_ telephone \_\_\_\_\_

**E) SIGNATURE:** By writing this durable power of attorney for health care, I inform those who may become entrusted with my care of my health care wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with my wishes as expressed in this document. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

**Signed this** \_\_\_\_\_ **day of** \_\_\_\_\_, **20**\_\_\_\_\_.  
signature \_\_\_\_\_  
address \_\_\_\_\_  
city \_\_\_\_\_ state \_\_\_\_\_

**F) WITNESSES:** I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me, and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative, nor as an alternate health care representative.

- |                        |                        |
|------------------------|------------------------|
| 1. witness _____       | 2. witness _____       |
| address _____          | address _____          |
| city _____ state _____ | city _____ state _____ |
| signature _____        | signature _____        |
| date _____             | date _____             |

**COMBINED ADVANCE DIRECTIVE FOR HEALTH CARE**  
*(Combined Proxy and Instruction Directive)*

I understand that as a competent adult I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction concerning my care and will turn to someone who knows my values and health care wishes. I understand that those responsible for my care will seek to make health care decisions in my best interests, based upon what they know of my wishes. In order to provide the guidance and authority needed to make decisions on my behalf:

I, \_\_\_\_\_ hereby declare and make known my instructions and wishes for my future health care. This advance directive for health care shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations. I direct that this document become part of my permanent medical records.

**In completing Part One of this directive, you will designate an individual you trust to act as your legally recognized health care representative to make health care decisions for you in the event you are unable to make decisions for yourself.**

**In completing Part Two of this directive, you will provide instructions concerning your health care preferences and wishes to your health care representative and others who will be entrusted with responsibility for your care, such as your physician, family members and friends.**

**Part One: Designation of a Health Care Representative**

**A) CHOOSING A HEALTH CARE REPRESENTATIVE:**

**I hereby designate:**

*name* \_\_\_\_\_

*address* \_\_\_\_\_

*city* \_\_\_\_\_ *state* \_\_\_\_\_

*telephone* \_\_\_\_\_

as my health care representative to make any and all health decisions for me, including decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, and decisions to provide, withhold or withdraw life-sustaining measures. I direct my representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear, or a situation arises I did not anticipate, my health care representative is authorized to make decisions in my best interests, based upon what is known of my wishes.

I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf.

**B) ALTERNATE REPRESENTATIVES:** If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in order of priority stated:

- |                        |                        |
|------------------------|------------------------|
| 1. name _____          | 2. name _____          |
| address _____          | address _____          |
| city _____ state _____ | city _____ state _____ |
| telephone _____        | telephone _____        |

**Part Two: Instruction Directive**

*In Part Two, you are asked to provide instructions concerning your future health care. This will require making important and perhaps difficult choices. Before completing your directive, you should discuss these matters with your health care representative, doctor, family members or others who may become responsible for your care.*

*In Sections C and D, you may state the circumstances in which various forms of medical treatment, including life-sustaining measures, should be provided, withheld or discontinued. If the options and choices below do not fully express your wishes, you should use Section E, and/or attach a statement to this document which would provide those responsible for your care with additional information you think would help them in making decisions about your medical treatment. **Please familiarize yourself with all sections of Part Two before completing your directive.***

**C) GENERAL INSTRUCTIONS:** To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding my health care:

**Initial ONE of the following two statements with which you agree:**

- |                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. ____ I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition | 2. ____ There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued. I recognize that this is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures. |
|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

*If you have initialed statement 2, on the following page please initial each of the statements (a, b, c) with which you agree:*

a. \_\_\_\_\_ I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition. If this occurs, and my attending physician and at least one additional physician who has personally examined me determine that my condition is **terminal**, I direct that life-sustaining measures which would serve only to artificially prolong my dying be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

**In the space provided, write in the bracketed phrase with which you agree:**

To me, terminal condition means that my physicians have determined that:

---

[I will die within a few days] [I will die within a few weeks]  
[I have a life expectancy of approximately \_\_\_\_\_ or less (enter 6 months, or 1 year)]

b. \_\_\_\_\_ If there should come a time when I become **permanently unconscious**, and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my capacity for interaction with other people and my surroundings, I direct that life-sustaining measures be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all medically appropriate care necessary to provide for my personal hygiene and dignity.

c. \_\_\_\_\_ I realize that there may come a time when I am diagnosed as having an **incurable and irreversible** illness, disease, or condition which may not be terminal. My condition may cause me to experience severe and progressive physical or mental deterioration and/or a permanent loss of capacities and faculties I value highly. If, in the course of my medical care, the burdens of continued life with treatment become greater than the benefits I experience, I direct that life-sustaining measures be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

*(Paragraph c. covers a wide range of possible situations in which you may have experienced partial or complete loss of certain mental and physical capacities you value highly. If you wish, in the space provided below you may specify in more detail the conditions in which you would choose to forego life-sustaining measures. You might include a description of the faculties or capacities, which, if irretrievably lost would lead you to accept death rather than continue living. You may want to express any special concerns you have about particular medical conditions or treatments, or any other considerations which would provide further guidance to those who may become responsible for your care. If necessary, you may attach a separate statement to this document or use **Section E** to provide additional instructions.)*

Examples of conditions which I find unacceptable are:

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**D) SPECIFIC INSTRUCTIONS: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR).** *On page 3 you provided general instructions regarding life-sustaining measures. Here you are asked to give specific instructions regarding two types of life-sustaining measures-artificially provided fluids and nutrition and cardiopulmonary resuscitation.*

**In the space provided, write in the bracketed phrase with which you agree:**

1. In the circumstances I initialed on page 3, I also direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion,

---

**[be withheld or withdrawn and that I be allowed to die]  
[be provided to the extent medically appropriate]**

2. In the circumstances I initialed on page 3, if I should suffer a cardiac arrest, I also direct that cardiopulmonary resuscitation (CPR)

---

**[not be provided and that I be allowed to die]  
[be provided to preserve my life, unless medically inappropriate or futile]**

3. If neither of the above statements adequately expresses your wishes concerning artificially provided fluids and nutrition or CPR, please explain your wishes below.

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**E) ADDITIONAL INSTRUCTIONS:** *(You should provide any additional information about your health care preferences which is important to you and which may help those concerned with your care to implement your wishes. You may wish to direct your health care representative, family members, or your health care providers to consult with others, or you may wish to direct that your care be provided by a particular physician, hospital, nursing home, or at home. If you are or believe you may become pregnant, you may wish to state specific instructions. If you need more space than is provided here you may attach an additional statement to this directive.)*

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**F) BRAIN DEATH:** *(The State of New Jersey recognizes the irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death), as a legal standard for the declaration of death. However, individuals who cannot accept this standard because of their personal religious beliefs may request that it not be applied in determining their death.)*

**Initial the following statement only if it applies to you:**

\_\_\_\_\_ To declare my death on the basis of the whole brain death standard would violate my personal religious beliefs. I therefore wish my death to be declared solely on the basis of the traditional criteria of irreversible cessation of cardiopulmonary (heartbeat and breathing) function.

**G) AFTER DEATH - ANATOMICAL GIFTS:** *(It is now possible to transplant human organs and tissue in order to save and improve the lives of others. Organs, tissues and other body parts are also used for therapy, medical research and education. This section allows you to indicate your desire to make an anatomical gift and if so, to provide instructions for any limitations or special uses.)*

**Initial the statements which express your wishes:**

1. \_\_\_\_\_ **I wish** to make the following anatomical gift to take effect upon my death:

- A. \_\_\_\_\_ any needed organs or body parts
  - B. \_\_\_\_\_ only the following organs or parts
- 

for the purposes of transplantation, therapy, medical research or education, or

- C. \_\_\_\_\_ my body for anatomical study, if needed.
  - D. \_\_\_\_\_ special limitations, if any:
- 

If you wish to provide additional instructions, such as indicating your preference that your organs be given to a specific person or institution, or be used for a specific purpose, please do so in the space provided below.

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2. \_\_\_\_\_ **I do not wish** to make an anatomical gift upon my death.

**Part Three: Signature and Witnesses**

**H) COPIES:** The original or a copy of this document has been given to the following people (*NOTE: If you have chosen to designate a health care representative, it is important that you provide him or her with a copy of your directive.*)

- |                        |                        |
|------------------------|------------------------|
| 1. name _____          | 2. name _____          |
| address _____          | address _____          |
| city _____ state _____ | city _____ state _____ |
| telephone _____        | telephone _____        |

The New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care

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**I) SIGNATURE:** By writing this advance directive, I inform those who may become entrusted with my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with this directive. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

**Signed this** \_\_\_\_\_ **day of** \_\_\_\_\_, **20**\_\_\_\_\_.  
*signature* \_\_\_\_\_  
*address* \_\_\_\_\_  
*city* \_\_\_\_\_ *state* \_\_\_\_\_

**J) WITNESSES:** I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative nor as an alternate health care representative.

1. *witness* \_\_\_\_\_  
*address* \_\_\_\_\_  
*city* \_\_\_\_\_ *state* \_\_\_\_\_  
*signature* \_\_\_\_\_  
*date* \_\_\_\_\_

2. *witness* \_\_\_\_\_  
*address* \_\_\_\_\_  
*city* \_\_\_\_\_ *state* \_\_\_\_\_  
*signature* \_\_\_\_\_  
*date* \_\_\_\_\_

## INSTRUCTION DIRECTIVE

I understand that as a competent adult I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction concerning my care and they will require information about my values and health care wishes. In order to provide the guidance and authority needed to make decisions on my behalf:

A) I, \_\_\_\_\_, hereby declare and make known to my family, physician, and others, my instructions and wishes for my future health care. I direct that all health care decisions, including decisions to accept or refuse any treatment, service or procedure used to diagnose, treat or care for my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining measures, be made in accordance with my wishes as expressed in this document. This instruction directive shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations. I direct that this document become part of my permanent medical records.

### **Part One: Statement of My Wishes Concerning My Future Health Care**

*In Part One, you are asked to provide instructions concerning your future health care. This will require making important and perhaps difficult choices. Before completing your directive, you should discuss these matters with your doctor, family members or others who may become responsible for your care.*

*In Section B and C, you may state the circumstances in which various forms of medical treatment, including life-sustaining measures, should be provided, withheld or discontinued. If the options and choices below do not fully express your wishes, you should use Section D, and/or attach a statement to this document which would provide those responsible for your care with additional information you think would help them in making decisions about your medical treatment. Please familiarize yourself with all sections of Part One before completing your directive.*

**B) GENERAL INSTRUCTIONS:** To inform those responsible for my care of my specific wishes, I make the following statement of personal views regarding my health care:

**Initial ONE of the following two statements with which you agree:**

1. \_\_\_\_\_ I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical or mental condition

2. \_\_\_\_\_ There are circumstances in which I would not want my life to be prolonged by further medical treatment. In these circumstances, life-sustaining measures should not be initiated and if they have been, they should be discontinued. I recognize that this is likely to hasten my death. In the following, I specify the circumstances in which I would choose to forego life-sustaining measures.

*If you have initialed statement 2 on page 1, please initial each of the statements (a, b, c) with which you agree:*

a. \_\_\_\_\_ I realize that there may come a time when I am diagnosed as having an incurable and irreversible illness, disease, or condition. If this occurs, and my attending physician and at least one additional physician who has personally examined me determine that my condition is **terminal**, I direct that life-sustaining measures which would serve only to artificially prolong my dying be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

**In the space provided, write in the bracketed phrase with which you agree:**

To me, terminal condition means that my physicians have determined that:

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[I will die within a few days] [I will die within a few weeks]  
[I have a life expectancy of approximately \_\_\_\_\_ or less (enter 6 months, or 1 year)]

b. \_\_\_\_\_ If there should come a time when I come **permanently unconscious**, and it is determined by my attending physician and at least one additional physician with appropriate expertise who has personally examined me, that I have totally and irreversibly lost consciousness and my capacity for interaction with other people and my surroundings, I direct that life-sustaining measures be withheld or discontinued. I understand that I will not experience pain or discomfort in this condition, and I direct that I be given all my medically appropriate care necessary to provide for my personal hygiene and dignity.

c. \_\_\_\_\_ I realize that there may come a time when I am diagnosed as having an **incurable and irreversible** illness, disease, or condition which may not be terminal. My condition may cause me to experience severe and progressive physical or mental deterioration and/or a permanent loss of capacities and faculties I value highly. If, in the course of my medical care, the burdens of continued life with treatment become greater than the benefits I experience, I direct that life-sustaining measures be withheld or discontinued. I also direct that I be given all medically appropriate care necessary to make me comfortable and to relieve pain.

*(Paragraph c. covers a wide range of possible situations in which you may have experienced partial or complete loss of certain mental and physical capacities you value highly. If you wish, in the space provided below you may specify in more detail the conditions in which you would choose to forego life-sustaining measures. You might include a description of the faculties or capacities, which, if irretrievably lost would lead you to accept death rather than continue living. You may want to express any special concerns you have about particular medical conditions or treatments, or any other considerations which would provide further guidance to those who may become responsible for your care. If necessary, you may attach a separate statement to this document or use **Section D** to provide additional instructions.)*

Examples of conditions which I find unacceptable are:

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**C) SPECIFIC INSTRUCTIONS: Artificially Provided Fluids and Nutrition; Cardiopulmonary Resuscitation (CPR).** *On page 2 you provided general instructions regarding life-sustaining measures. Here you are asked to give specific instructions regarding two types of life-sustaining measures-artificially provided fluids and nutrition and cardiopulmonary resuscitation.*

**In the space provided, write in the bracketed phrase with which you agree:**

1. In the circumstances I initialed on page 2, I also direct that artificially provided fluids and nutrition, such as by feeding tube or intravenous infusion,

---

**[be withheld or withdrawn and that I be allowed to die]  
[be provided to the extent medically appropriate]**

2. In the circumstances I initialed on page 2, if I should suffer a cardiac arrest, I also direct that cardiopulmonary resuscitation (CPR)

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**[not be provided and that I be allowed to die]  
[be provided to preserve my life, unless medically inappropriate or futile]**

3. If neither of the above statements adequately expresses your wishes concerning artificially provided fluids and nutrition or CPR, please explain your wishes below.

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**D) ADDITIONAL INSTRUCTIONS:** *(You should provide any additional information about your health care preferences which is important to you and which may help those concerned with your care to implement your wishes. You may wish to direct your family members or your health care providers to consult with others, or you may wish to direct that your care be provided by a particular physician, hospital, nursing home, or at home. If you are or believe you may become pregnant, you may wish to state specific instructions. If you need more space than is provided here you may attach an additional statement to this directive.)*

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**E) BRAIN DEATH:** *(The State of New Jersey recognizes the irreversible cessation of all functions of the entire brain, including the brain stem (also known as whole brain death), as a legal standard for the declaration of death. However, individuals who cannot accept this standard because of their personal religious beliefs may request that it not be applied in determining their death.)*

**Initial the following statement only if it applies to you:**

\_\_\_\_\_ To declare my death on the basis of the whole brain death standard would violate my personal religious beliefs. I therefore wish my death to be declared solely on the basis of the traditional criteria of irreversible cessation of cardiopulmonary (heartbeat and breathing) function.

**F) AFTER DEATH - ANATOMICAL GIFTS:** *(It is now possible to transplant human organs and tissue in order to save and improve the lives of others. Organs, tissues and other body parts are also used for therapy, medical research and education. This section allows you to indicate your desire to make an anatomical gift and if so, to provide instructions for any limitations or special uses.)*

**Initial the statements which express your wishes:**

1. \_\_\_\_\_ **I wish** to make the following anatomical gift to take effect upon my death:

- A. \_\_\_\_\_ any needed organs or body parts
- B. \_\_\_\_\_ only the following organs or parts

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for the purposes of transplantation, therapy, medical research or education, or

- C. \_\_\_\_\_ my body for anatomical study, if needed.
- D. \_\_\_\_\_ special limitations, if any:

---

If you wish to provide additional instructions, such as indicating your preference that your organs be given to a specific person or institution, or be used for a specific purpose, please do so in the space provided below.

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2. \_\_\_\_\_ **I do not wish** to make an anatomical gift upon my death.

**Part Two: Signature and Witnesses**

**G) COPIES:** The original or a copy of this document has been given to the following people (*NOTE: It is important that you provide a family member, friend or your physician with a copy of your directive.*):

- |                        |                        |
|------------------------|------------------------|
| 1. name _____          | 2. name _____          |
| address _____          | address _____          |
| city _____ state _____ | city _____ state _____ |
| telephone _____        | telephone _____        |

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**H) SIGNATURE:** By writing this advance directive, I inform those who may become entrusted with my health care of my wishes and intend to ease the burdens of decision making which this responsibility may impose. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

signature \_\_\_\_\_

address \_\_\_\_\_

city \_\_\_\_\_ state \_\_\_\_\_

**D) WITNESSES:** I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative nor as an alternate health care representative.

1. witness \_\_\_\_\_

address \_\_\_\_\_

city \_\_\_\_\_ state \_\_\_\_\_

signature \_\_\_\_\_

date \_\_\_\_\_

2. witness \_\_\_\_\_

address \_\_\_\_\_

city \_\_\_\_\_ state \_\_\_\_\_

signature \_\_\_\_\_

date \_\_\_\_\_



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**Notes:**



# Checklist: Questions to Ask Yourself

## I. Thinking about Your Health Care Wishes?

- A. Why am I writing an advance directive?
- B. What are my treatment wishes?
  - 1. in situations near the end of life?
  - 2. in situations of serious injury or illness?

## II. Talking with Others

- A. Physicians and other health care professionals
  - 1. do I understand the medical terminology?
  - 2. do they understand my wishes?
- B. My friends, family and others
  - 1. have I directly and thoroughly discussed my wishes with them?
  - 2. do they understand my wishes?

## III. Selecting a Health Care Representative

- A. Am I confident that my designated representative understands my personal values and health care wishes?
- B. Does my health care representative understand his or her responsibilities?
- C. Has he or she clearly agreed to serve as my representative and to communicate my wishes to my doctor and other concerned with my care?
- D. Have I selected an alternative health care representative?

## IV. My Instructions. Have I clearly stated my instructions and included other relevant information about my treatment wishes regarding:

- A. the provision, withholding or withdrawal of specific treatments?
- B. artificially provided fluids and nutrition?
- C. the medical conditions in which I want my wishes implemented?
- D. special considerations I may have concerning my care and treatment?

## V. Witnesses. Have I had my directive properly witnessed?

## VI. Distribution of My Advance Directive. Have I given a copy of my directive to those who should have one, such as:

- A. my health care representative?
- B. my physician or other health care provider?
- C. the hospital or nursing home which I am about to enter?
- D. family members, friends, alternate representatives and my religious advisor?

## VII. Periodic Review. Have I made a note to review my directive on a regular basis in the future?

## VIII. Wallet Card. Have I completed the wallet size card located on the inside back cover of this brochure which tells others I have an advance directive and who to contact for further information?

### I HAVE AN ADVANCE DIRECTIVE FOR HEALTH CARE

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_

*for information please contact as soon as possible:*

Name: \_\_\_\_\_ tel.# \_\_\_\_\_

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

City: \_\_\_\_\_ State \_\_\_\_\_

**OR**

Name: \_\_\_\_\_ tel.# \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_

### ORGAN DONOR CARD

In the hope that I may help others, I hereby make this anatomical gift, to take effect upon my death. The words and marks below indicate my desires.

I give: \_\_\_\_\_ Any needed organs or parts

or: \_\_\_\_\_ Only the following organs or parts.

\_\_\_\_\_

For the purposes of transplantation, therapy, medical research or education.

Signed by the Donor and the following two witnesses in the presence of each other.

Signature of donor \_\_\_\_\_ Date of birth \_\_\_\_\_  
of Donor \_\_\_\_\_

Date Signed \_\_\_\_\_ City & State \_\_\_\_\_

Witness \_\_\_\_\_ Witness \_\_\_\_\_

This Is A Legal Document Under the Uniform Anatomical Gift Act.