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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
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.

- Warning to person executing this document -

This is an important legal document. Before executing this document you should know these important facts:

This document gives the person you designate as your agent (your attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent: (1) authorizes anything that is illegal; or (2) acts contrary to your desires as stated in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to: (1) authorize an autopsy; (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes; and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask an attorney to explain it to you.

[Tennessee Code Annotated, § 34-6-205; Durable Power Of Attorney For Health Care]

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By signing this document, I appoint the person I name on page 2 to make health care decisions for me if I am ever unable to make them for myself. I intend for this person to ensure that my living will is honored and that decisions about my medical care respect my wishes as far as they are known. I intend for this person to have the broadest discretion and power allowed by law to approve, refuse or stop medical care for me.

If I should ever reach the point at which my doctor believes I am going to die no matter what is done, I direct this person to ensure that I am allowed to die naturally. That means not starting or continuing to use machines or treatments that would only prolong my dying.

At that point, this person should ensure that I have only the medicine or treatment that I need to keep me comfortable and relieve pain.

In the situation described here,

I authorize ☐ do not authorize ☐ this person to approve a treatment or medicine to keep me comfortable and out of pain, <u>even if</u> it may cause permanent physical damage or addiction or hasten my death.

If I cannot take food and/or liquids by mouth in the situation described here,

I authorize ☐ do not authorize ☐ this person to refuse or stop artificial feeding, such as giving me nourishment or fluids through a tube or a vein.

I want this person to have my power of attorney to do the things described on the first page:

Person to have Power of Attorney for Health Care (Attorney in Fact):

Name: _____

Street Address: _____

City: _____ State: _____ Phone: _____

If the person named above is unable or unwilling to serve, I appoint the following person as my successor (backup) attorney in fact with full powers and responsibilities to make health care decisions on my behalf.

Backup Person to have Power of Attorney for Health Care (Successor Attorney in Fact):

Name: _____

Street Address: _____

City: _____ State: _____ Phone: _____

I authorize the use of copies of this document.

I hereby execute this Durable Power of Attorney For Health Care on the _____ day of _____, 20__.

My signature: _____
Person giving the Power of Attorney for Health Care (Principal)

Declaration of Witnesses

Each of the undersigned witnesses makes the following declaration: "I declare under penalty of perjury under the laws of Tennessee that the person who signed this document is personally known to me to be the principal; that the principal signed this durable power of attorney in my presence; that the principal appears to be of sound mind and under no duress, fraud or undue influence; that I am not the person appointed as attorney in fact by this document; that I am not a health care provider, an employee of a health care provider, the operator of a health care institution nor an employee of an operator of a health care institution; that I am not related to the principal by blood, marriage, or adoption; that, to the best of my knowledge, I do not, at the present time, have a claim against any portion of the estate of the principal upon the death of the principal; and, that, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will or codicil thereto now existing, or by operation of law."

_____ _____

Signature of Witness
Date: _____

Signature of Witness
Date: _____

STATE OF TENNESSEE
COUNTY OF _____

Subscribed, sworn to and acknowledged before me by _____, the principal, and subscribed and sworn to before me by _____ and _____, witnesses, this _____ day of _____, 20___.

_____ My commission expires: _____

Notary Public