

Medical Directive

Executed by _____ name _____, regarding my medical care.

I _____ name _____, residing at _____ address _____ in _____ city _____, state, hereby designated _____ name _____, residing at _____ address _____ in _____ city _____, state, with telephone number _____ phone _____ to hold Durable Power of Attorney for Health Care on my behalf. The following terms and conditions apply until such time that it is revoked by me in writing and are otherwise irrevocable.

1. Authority to Act on my Behalf. If I cannot make medical decisions for myself, I hereby authorize the party holding Power of Attorney to act on my behalf in accordance with the wishes I have laid out below. My designee shall convey my intent to doctors, family members, and others needing such guidance.

2. Terminal Condition. If I am determined to have a terminal condition I desire:

a. Life-sustaining treatment such as CPR be started.

___ yes ___ no ("do not resuscitate")

b. If life-sustaining treatment is nonetheless started, I want it to stop:

___ yes ___ no

c. I prefer that physicians use whatever life-sustaining treatments they determine are in my best interest.

___ yes ___ no

d. If artificial nutrition and hydration would be the main treatment to keep me alive, I do not want them started, and if nonetheless started, I want them stopped.

___ yes ___ no

e. My top priority is being kept as comfortable and pain-free as possible, regardless of whether this prolongs or shortens my life.

___ yes ___ no

3. Persistent Vegetative State. If I am determined to be in a persistent vegetative state, I desire:

a. Life-sustaining treatment such as CPR be started.

___ yes ___ no

b. If life-sustaining treatment is nonetheless started, I want it to stop:

___ yes ___ no

c. I prefer that physicians use whatever life-sustaining treatments they determine are in my best interest.

___ yes ___ no

d. If artificial nutrition and hydration would be the main treatment to keep me alive, I do not want them started, and if nonetheless started, I want them stopped.

___ yes ___ no

e. My top priority is being kept as comfortable and pain-free as possible, regardless of whether this prolongs or shortens my life.

___ yes ___ no

4. Organ Donation. In the event of my death, if my organs are deemed acceptable for donation:

a. I wish to donate any/all organs and tissues.

___ yes ___ no

b. I wish to donate only the following organs and tissues:

c. I do not wish to donate any organs or tissues.

___ yes ___ no

5. Medical Autopsy. In the event of my death:

a. I don't want an autopsy.

___ yes ___ no

b. I consent to an autopsy if my physicians find it appropriate.

___ yes ___ no

6. Substitute. If _____ name _____ is unable or unwilling to act on my behalf, I hereby grant Power of Attorney to _____ name _____, residing at _____ address _____ in _____ city _____, state with phone number _____ phone _____.

I hereby certify that I am signing this advance directive while of sound mind and under no duress. This document must be witnessed by two parties not related to me by blood, marriage, or adoption, nor by anyone named in my will nor by a health care provider involved in my care.