

HEALTH CARE DIRECTIVE

My Health Care Agent

I, _____, trust and appoint _____ as my health care agent. As my health care agent, this person can make health care decisions for me if I am unable to make and communicate health care decisions for myself. If my health care agent is not reasonably available, I trust and appoint _____ to be my agent instead.

Health Care Agent Information:

Name: _____
Address: _____
Phone number: _____ Relationship to you: _____

Alternate Health Care Agent Information:

Name: _____
Address: _____
Telephone number: _____ Relationship to you: _____

My Wishes

This is what I want my health care agent- or if I have no health care agent, whoever will make decisions regarding my care- to do if I am unable to make and communicate health care decisions for myself. Most of what I state here is general in nature since I cannot anticipate all the possible circumstances of a future illness. If I have not given specific instructions, then my agent must decide consistent with my wishes and beliefs.

I add the following directives: (You do not need to complete this section. You can add an extra page, if needed, but sign and date any extra pages.)

Making an Anatomical Gift

I would like to be an organ donor at the time of my death. I wish to donate the following (initial one statement):

_____ Any needed organs and tissues.
_____ Only the following organs and tissue: _____.

Date and Signature of Principal

I sign my name to this Health Care Directive on _____ (date)
at _____ (city) _____ (state).

_____ (you sign here)

(This health care directive will not be valid unless it is notarized or signed by two qualified witnesses who are present when you sign or acknowledge your signature. If you have attached any additional pages to this form, you must date and sign each of the additional pages at the same time you date and sign this health care directive.)

Notary Public or Statement of Witnesses

The person notarizing this document may be an employee of a health care or long-term care provider providing your care. At least one witness to the execution of the document must not be a health care or long-term care provider providing you with direct care or an employee of the health care or long-term care provider providing you with direct care.

None of the following may be used as a notary or witness: 1. A person you designate as your agent or alternate agent; 2. Your spouse; 3. A person related to you by blood, marriage, or adoption; 4. A person entitled to inherit any part of your estate upon your death; or 5. A person who has, at the time of executing this document, any claim against your estate.

Option 1: Notary Public

In my presence on _____ (date), _____ (name of declarant) acknowledged the declarant’s signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant’s behalf.

_____, 20_____
(Signature of Notary Public) My commission expires

Option 2: Two Witnesses:

Witness One:

(1) In my presence on _____ (date), _____ (name of declarant) acknowledged the declarant’s signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant’s behalf.

(2) I am at least eighteen years of age.

(3) If I am a health care provider or an employee of a health care provider giving direct care to the declarant, I must initial this box: [_____].

I certify that the information in (1) through (3) is true and correct.

(Signature of Witness One) (Address)

Witness Two:

(1) In my presence on _____ (date), _____ (name of declarant) acknowledged the declarant’s signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant’s behalf.

(2) I am at least eighteen years of age.

(3) If I am a health care provider or an employee of a health care provider giving direct care to the declarant, I must initial this box: [_____].

I certify that the information in (1) through (3) is true and correct.

(Signature of Witness Two) (Address)

Acceptance of Appointment by Health Care Agent

I accept this appointment and agree to serve as a health care agent. I understand I have a duty to act in good faith, consistent with the desires expressed in this document, and that this document gives me authority to make health care decisions for the principal only when he or she is unable to make and communicate his or her own decisions. I understand that the principal may revoke this appointment at any time, in any manner.

If I choose to withdraw during the time the principal is competent, I must notify the principal of my decision. If I choose to withdraw when the principal is not competent, I must notify the principal's physician.

(Signature of Agent/Date)

(Signature of Alternate Agent/Date)

Principal's Statement

I have read a written explanation of the nature and effect of an appointment of a health care agent that is attached to my health care directive.

Dated on _____, 20____.

Signature of Principal