ADVANCE HEALTH CARE DIRECTIVE

INSTRUCTIONS: This form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes. This form also lets you express an intention to donate your bodily organs and tissues following your death. Lastly, this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health-care agents you have named.

I, , being of sound mind and at least 18 years of age, declare that:

(1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Initial only one box)

[___] (a) Choice NOT To Prolong Life. I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

[___] (b) Choice To Prolong Life. I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

_____

_____

_____.

(3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

_____

(4) PRIMARY PHYSICIAN -(OPTIONAL).

I designate the following physician as my primary physician:

_____

(name of physician)

_____

(address) (city) (state) (zip code)

_____

(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____

(name of physician)

_____

(address) (city) (state) (zip code)

_____

(phone)

(5) DONATION OF ORGANS AT DEATH - (OPTIONAL).

Upon my death: (mark applicable box)

[___] (a) I give any needed organs, tissues, or parts, OR

[___] (b) I give the following organs, tissues, or parts only.

[___] (c) My gift is for the following purposes: (strike any of the following you do not want)

- (1) Transplant
- (2) Therapy
- (3) Research
- (4) Education

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from such refusal.

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

I execute this declaration, as my free and voluntary act, on this _____ day of _____, 2010, in the City of , County of , State of .

_____

(INSTRUCTIONS: This advance health care directive will not be valid for making health care decisions unless it is either: (1) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (2) acknowledged before a notary public.)

I declare under penalty of perjury under the laws of the state of (1) that the individual who signed or acknowledged this advance health care directive is personally known to

me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community health care facility, the operator of a community health care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

I further declare under the laws of penalty of perjury of the state of that I am neither related to the patient by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any portion of the patient's estate upon the patient's death under a will existing when the advance directive is executed or by operation of law.

Signed at _____, , on this ____ day of _____, 2010.

_____

(name and address of first witness)

_____

(name and address of second witness)

State of _____)

) ss

County of _____)

On this the _____ day of _____, 2010, before me, the undersigned, a notary public in and for said County and State, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

_____

Signature of Notary