

## ADVANCE HEALTH CARE DECLARATION

I, \_\_\_\_\_ being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment:

I ( ) do ( ) do not want cardiac resuscitation.

I ( ) do ( ) do not want mechanical respiration.

I ( ) do ( ) do not want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).

I ( ) do ( ) do not want blood products.

I ( ) do ( ) do not want any form of surgery or invasive diagnostic tests.

I ( ) do ( ) do not want kidney dialysis.

I ( ) do ( ) do not want antibiotics.

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

### **Other instructions:**

I direct that if I am pregnant all medically indicated measures and medically assisted nutrition and hydration be provided to sustain my life, regardless of my physical or mental condition, if these measures could sustain the life of my unborn child until birth.

I ( ) do ( ) do not want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and in a terminal condition or in a state of permanent unconsciousness. Name and address of surrogate (if applicable):

Name and address of substitute surrogate (if surrogate designated above is unable to serve):

I ( ) do ( ) do not want to make an anatomical gift of all or part of my body, subject to the following limitations, if any:

I made this declaration on the \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_.

Declarant's signature: \_\_\_\_\_

Declarant's address: \_\_\_\_\_  
\_\_\_\_\_

The declarant or the person on behalf of and at the direction of the declarant knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness's signature: \_\_\_\_\_

Witness's address: \_\_\_\_\_  
\_\_\_\_\_

Witness's signature: \_\_\_\_\_

Witness's address: \_\_\_\_\_  
\_\_\_\_\_