Health Care Directive
of

_____

[My Name]

I am of sound mind and body and voluntarily execute this health care directive. If I cannot make decisions for myself about life sustaining medical treatment, my relatives, friends, agents and medical providers should fully honor every part of this directive. If any part of this directive is invalid, the remainder should be honored. I revoke any health care directives I have signed in the past.

1. Withhold or Withdraw Treatment. If my attending physician diagnoses me with a terminal condition, or if two physicians determine that I am in a permanent unconscious condition, and if my physician(s) determine that life-sustaining treatment would only artificially prolong the process of dying, the following treatment should be withheld or withdrawn from me: (check all that apply)

☐ Artificial nutrition

☐ Artificial hydration

☐ Artificial respiration

☐ Cardiopulmonary Resuscitation (CPR), including artificial ventilation, heart regulating drugs, diuretics, stimulants, or any other treatment for heart failure

☐ Surgery to prolong my life or keep me alive

☐ Blood dialysis or filtration for lost kidney function

☐ Blood transfusion to replace lost or contaminated blood

☐ Medication used to prolong life, not for controlling pain

☐ Any other medical treatment used to prolong my life or keep me alive artificially

2. Comfort Care and Pain Medication. If I appear to be experiencing pain or discomfort, I want treatment and medications to make me comfortable, even if my medical providers believe it might unintentionally hasten my death.

3. Health Care Institutions. If I am admitted to a hospital or other medical institution that will not honor this directive due to religious or other beliefs: (1) my consent to admission is not implied consent to treatment, and (2) I want to be transferred as soon as possible to a hospital or other medical institution that will honor my directive.

4. Changes and Revocation. I understand that I can change the wording of this directive before I sign it. I also understand that I can revoke this directive at any time.

5. Additional Directions: I make the following additional directions regarding my care:

I have signed this document in the presence of two witnesses.

_____ _____

My Signature Date

Statement of Witnesses

On _____, the declarer of this document signed it in my presence. I believe the declarer is able to make health care decisions, to understand this document, and to have signed it voluntarily.

- I am not related by blood or marriage to the declarer.
- I am not now entitled to receive any portion of the declarer's estate, either by will or by operation of law, or as a result of any claim against the declarer.
- I am not the declarer's attending physician or an employee of that physician or of a health facility in which the declarer is a patient.

Witness 1	Witness 2
_____	_____
Signature	Signature
_____	_____
Name	Name
_____	_____
Address	Address