

**HEALTH CARE DIRECTIVE**  
**OF**

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This Health Care Directive shall revoke any prior document granting a power in conflict with a power granted herein. I, \_\_\_\_\_, born on \_\_\_\_\_, and currently residing at \_\_\_\_\_ understand this document allows me to do **ONE OR BOTH** of the following:

PART I: Name another person ("health care agent") to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, the wishes I have made known to him or her, or must act in my best interest if I have not made my health care wishes known.

AND/OR

PART II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care and my family, in the event I cannot make decisions for myself.

**PART I**  
**POWER OF ATTORNEY APPOINTING HEALTH CARE AGENT**

**This Is Who I Want to Make Health Care Decisions for Me If I Am Unable to Decide or Speak for Myself**

NOTE: If you appoint an agent, you should discuss this health care directive with your agent and give your agent a copy. If you do not wish to appoint an agent, you may leave Part I blank and go to Part II.

If I am unable to decide or communicate my instructions, I designate the following person(s) as my health care agent to make health care decisions for me and act on my behalf consistently with my instructions, if any, as stated or limited in this document. If a guardian or conservator of the person is to be appointed for me, I nominate my agent named in this document to act as guardian or conservator of my person.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

If that person I have named above refuses or is not reasonably available to act on my behalf, or if I revoke that person's authority to act as my agent, I authorize the following person to do so:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_

**This Is What I Want My Health Care Agent to Be Able to  
Do If I Am Unable to Decide or Speak for Myself  
(I know I can change these choices)**

My health care agent is given the powers indicated below in (A) through (D). My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest.

Whenever I am unable to decide or speak for myself, my health care agent is given the powers indicated by my initials below:

\_\_\_\_\_ (A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.

\_\_\_\_\_ (B) Choose my health care providers.

\_\_\_\_\_ (C) Choose where I live and receive care and support when those choices relate to my health care needs.

\_\_\_\_\_ (D) Review my medical records and have the same rights that I would have to give my medical records to other people.

I choose to LIMIT a power granted in (A) through (D), as follows:

NO LIMITATIONS

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My health care agent is given the powers indicated by my initials below in (1) and (2).

\_\_\_\_\_ (1) To decide whether to donate my organs when I die.

\_\_\_\_\_ (2) To decide what will happen with my body when I die (burial, cremation).

Additional comments regarding my health care agent=s powers or limits on the powers:

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**PART II  
HEALTH CARE INSTRUCTIONS**

NOTE: Complete this Part II if you wish to give health care instructions. If you appointed an agent in Part I, completing this Part II is optional but would be very helpful to your agent. However, if you chose not to appoint an agent in Part I, you **MUST** complete some or all of this Part II if you wish to make a valid health care directive.

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs).

**THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE**

I want you to know these things about me to help you make decisions about my health care:

My goals for my health care: \_\_\_\_\_

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My fears about my health care: \_\_\_\_\_

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My spiritual or religious beliefs and traditions: \_\_\_\_\_

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My beliefs about when life would be no longer worth living: \_\_\_\_\_

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My thoughts about how my medical condition might affect my family: \_\_\_\_\_

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## THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

Many medical treatments may be used to try to improve my medical condition or to prolong my life. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start a stopped heart, surgeries, dialysis, antibiotics and blood transfusions. Most medical treatments can be tried for a while and then stopped if they do not help.

I have these views about my health care in these situations:

(Note: You can discuss general feelings, specific treatments, or leave any of them blank.)

If I had a reasonable chance of recovery, and were temporarily unable to decide or speak for myself, I would want \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If I were dying and unable to decide or speak for myself, I would want \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If I were permanently unconscious and unable to decide or speak for myself, I would want \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If I were completely dependent on others for my care and unable to decide or speak for myself, I would want \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In all circumstances, my doctors should try to keep me comfortable and reduce my pain. This is how I feel about pain relief if it would affect my alertness or if it could shorten my life: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

There are other things that I want or do not want for my health care, if possible:

Who I would like to be my doctor: \_\_\_\_\_

Where I would like to live to receive health care: \_\_\_\_\_

Where I would like to die or other wishes I have about dying: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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My wishes about donating parts of my body when I die: \_\_\_\_\_

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My wishes about what happens to my body when I die (cremation, burial): \_\_\_\_\_

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Any other things: \_\_\_\_\_

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Date: \_\_\_\_\_, 200\_\_

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

\_\_\_\_\_  
(Signature of Principal )

[If I cannot sign my name, I can ask someone to sign this document for me.

\_\_\_\_\_  
Signature of the person who I asked to sign  
this document for me.

\_\_\_\_\_  
Printed name of the person who I asked to  
sign this document for me.

**WITNESS**

I certify that I am at least 18 years of age and that in my presence on the date appearing above, the principal, \_\_\_\_\_, personally known to me, voluntarily signed this instrument. I am not named as agent or alternative agent in the instrument. I (am ) ( am not \_\_\_) a Health Care Provider or employee of a Health Care Provider providing direct care to \_\_\_\_\_.

Witness \_\_\_\_\_ residing at \_\_\_\_\_

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