

## ADVANCE HEALTH CARE DECLARATION

I, \_\_\_\_\_ (the responsible party for) \_\_\_\_\_, direct the 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 strongly 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 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  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):

I made this declaration on the \_\_\_\_\_ day of \_\_\_\_\_ 200\_ (month/year)

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' Signature: \_\_\_\_\_

Witness' Address: \_\_\_\_\_

\_\_\_\_\_

Witness' Signature: \_\_\_\_\_

Witness' Address: \_\_\_\_\_

\_\_\_\_\_