Section XXX. Optional Form

The following form may, but need not, be used to create an advance health-care directive. The other sections of this [act] govern the effect of this or any other record used to create an advance health-care directive. An individual may complete or modify all or any part of the following form:

ADVANCE HEALTH-CARE DIRECTIVE

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you if you cannot make those decisions for yourself. You can use this form to do both of these things. You can also use it to say if you want to be an organ donor when you die.

Using this form is optional. You may use other forms instead or make your own form.

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PART 1

POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I want the following individual to make health care decisions for me if I cannot make those decisions for myself:

It is recommended that you provide the full name, address, phone number, and email address of the individual you are naming.

(2) DESIGNATION OF BACK-UP AGENT: I want the following individual to make health care decisions for me if I cannot make those decisions for myself and my first agent is not willing, able, or reasonably available to make them for me.

It is recommended that you provide the full name, address, phone number, and email address of the individual you are naming.

(3) LIMITS ON AGENT'S AUTHORITY: I give my agent the power to make all health-care decisions for me if I cannot make those decisions for myself, except as I state here:

If you do not add any limitations on your agent's power, your agent will have the ability to make all healthcare decisions that an agent is permitted to make under State law.

PART 2
HEALTH CARE INSTRUCTION

This form allows you to indicate what types of health care you do and do not want. Your health care providers must generally follow these instructions unless you give them different instructions. If you do not know what you want, you can leave all or part of this this section blank.

(1) INSTRUCTIONS ABOUT LIFE AND LIFE-SUSTAINING CARE

If I have an incurable and irreversible condition that is expected to result in my death in a relatively short time, I want to (*initial or mark your choices*):

[ ] remain alive as long as possible
[ ] not be given health care treatment merely to prolong my life
[ ] not be given artificial nutrition or hydration merely to prolong my life
[ ] other (please write what you want):

If I am unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, I want to (*initial or mark your choices*):

[ ] remain alive as long as possible
[ ] not be given health care treatment merely to prolong my life
[ ] not be given artificial nutrition or hydration merely to prolong my life
[ ] other (please write what you want):

If I have permanent and severe brain damage from which I am not expected to recover, I want to (*initial or mark your choices*):

[ ] remain alive as long as possible
[ ] not be given health care treatment merely to prolong my life
[ ] not be given artificial nutrition or hydration merely to prolong my life
[ ] other (please write what you want):

Other end-of-life preferences:

You can use this section to state other preferences for life-sustaining care. If there are conditions that you do not want to be kept alive in, or other types of care that you do not want, you can specify that here.

(2) INSTRUCTION ABOUT PRIORITIES: You can use this section of the form to indicate what is important to you, and what is not important to you. This information can help others make decisions for you if you cannot make them for yourselves. You may leave all or part of this section blank.

Staying alive as long as possible, even if I have substantial physical or mental limitations (*initial or mark your choice*):

[ ] Very important
[ ] Somewhat important
[ ] Not important

Not being in pain (*initial or mark your choice*):

[ ] Very important
[ ] Somewhat important
[ ] Not important

Being independent (*initial or mark your choice*):

[ ] Very important
[ ] Somewhat important
[ ] Not important

Having my family and friends involved in making decisions about my care (*initial or mark your choice*):

[ ] Very important
[ ] Somewhat important
[ ] Not important

Other (please feel free to share other values and goals that are important to you):

(3) OTHER INSTRUCTIONS

You can use this section to provide any other instructions about the health care you want or do not want.

(4) OPTIONAL GUIDANCE FOR AGENT:
Initial or mark your choice if you want to provide your agent with some more guidance about how to use your instructions.

[ ] My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I give them permission to be flexible in applying these statements if they think that doing so would be in my best interest.

[ ] My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, and I want them to follow my stated preferences exactly as written, even if they think that some alternative is better.

[ ] Other (feel free to provide other guidance):

If you want to give your agent and health care providers some guidance about how to treat your instructions, you use this section to do that.

PART 3

DONATION OF ORGANS AT DEATH

Upon my death (initial or mark the box that indicates what you want; you can leave this section blank if you wish):

[ ] I give my organs, tissues, and other body parts

[ ] I donate the following organs, tissues, or body parts only *(list the ones you want to give)*:

My gift is for the following purposes (*strike any of the following you do not want*):

- Transplant
- Therapy
- Research
- Education

PART 4

NOMINATION OF GUARDIAN

If a court finds that a guardian needs to be appoint for me, I nominate

[ ] The agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

[ ] The following person (please state the person's name):

PART 5
SIGNATURES

My name:

My signature:

Date I signed (Month, Day, Year):

Optional: My date of birth (Month, Day, Year)

Optional: My contact information (you may include your address, phone number, email address, or other contact information):

Witness name (a witness is needed if you are using this document to name an agent):

Witness signature:

Witness address (providing the witness's full address is recommended):

Date witness signed:

PART 6

INFORMATION FOR PEOPLE USING THIS ADVANCE DIRECTIVE

Information for Agents

If you are named as agent under this document, you may make a decision for the individual who named you as agent if that individual is unable to make their own decisions. In making decisions, you should follow any instructions an individual has given you, including any listed in this document. If you don't know what the individual would want, you should make the decision that you believe is in the individual's best interest. To figure out what the individual's best interest is, you must consider the individual's (1) personal values and preferences to the extent you know them or could reasonably learn them; and (2) what the individual currently indicates they want, even if these indications are nonverbal.

Information for Health Care Providers

A copy of this form has the same effect as the original.