
(Date)

(Signature of Declarant)

The declarant signed or acknowledged signing this appointment of a health care agent in my presence and based upon my personal observation appears to be a competent individual.

(Witness)

(Witness)

(Signature of Two Witnesses)

Part B
Advance Medical Directive
Health Care Instructions

(Optional Form)

(Cross through if you do not want to complete this portion of the form. If you do want to complete this portion of the form, initial those statements you want to be included in the document and cross through those statements that do not apply.)

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below. (Initial all those that apply.)

(1) If my death from a terminal condition is imminent and even if life-sustaining procedures are used there is no reasonable expectation of my recovery -

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

(2) If I am in a persistent vegetative state, that is, if I am not conscious and am not aware of my environment or able to interact with others, and there is no reasonable expectation of my recovery -

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.