(DATE) (SIGNATURE OF DECLARANT)

THE DECLARANT SIGNED OR ACKNOWLEDGED SIGNING THIS LIVING WILL IN MY PRESENCE AND BASED UPON MY PERSONAL OBSERVATION THE DECLARANT APPEARS TO BE A COMPETENT INDIVIDUAL.

(WITNESS) (WITNESS)

(SIGNATURE OF TWO WITNESSES)

FORM II

ADVANCE DIRECTIVE

PART A

APPOINTMENT OF HEALTH CARE AGENT

(OPTIONAL FORM)

(CROSS THROUGH IF YOU DO NOT WANT TO APPOINT A HEALTH CARE AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU. IF YOU DO WANT TO APPOINT AN AGENT, CROSS THROUGH ANY ITEMS IN THE FORM THAT YOU DO NOT WANT TO APPLY.)

(1) I, ____________________, RESIDING AT ____________________

APPOINT THE FOLLOWING INDIVIDUAL AS MY AGENT TO MAKE HEALTH CARE DECISIONS FOR ME

(FULL NAME, ADDRESS, AND TELEPHONE NUMBER)

OPTIONAL: IF THIS AGENT IS UNAVAILABLE OR IS UNABLE OR UNWILLING TO ACT AS MY AGENT, THEN I APPOINT THE FOLLOWING PERSON TO ACT IN THIS CAPACITY

(FULL NAME, ADDRESS, AND TELEPHONE NUMBER)

(2) MY AGENT HAS FULL POWER AND AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING THE POWER TO:

A. REQUEST, RECEIVE, AND REVIEW ANY INFORMATION, ORAL OR WRITTEN, REGARDING MY PHYSICAL OR MENTAL HEALTH, INCLUDING, BUT NOT LIMITED TO, MEDICAL AND HOSPITAL RECORDS, AND CONSENT TO DISCLOSURE OF THIS INFORMATION;