The following is the Advance Directive for Healthcare statutory form:

Declaration

I, ______________________________, being of sound mind, willingly and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my 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 life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strong 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).
I  □  do  □  do not want tube feeding or any other artificial or invasive form of hydration (water).
I  □  do  □  do not want blood or blood products.
I  □  do  □  do not want any form of surgery or invasive diagnostic tests.
I  □  do  □  do not want kidney dialysis.
I  □  do  □  do not want antibiotics.

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)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Name and address of substitute surrogate (if surrogate designated above is unable to serve)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

continued on reverse side
I □ do  □ do not want to make an anatomical gift of all or part of my body, subject to the following limitations (if any).

I made this declaration on the ___________ day of _______________ month, 20______________

Declarant: ______________________________________________________

Signature: ______________________________________________________

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: ______________________________________________________

Address: ______________________________________________________

Witness: ______________________________________________________

Signature: ______________________________________________________

Address: ______________________________________________________