

ADVANCE CARE PLAN

I _____ want to choose how I will be treated during the last days of my life. I request to be given medical treatment fully sufficient to prevent unnecessary suffering, including pain, suffocation, and emotional and psychological stress. When I can no longer make my own health care choices, I direct my physician(s), other health care providers and my health care surrogate(s) to follow the advance directives of this document. My choices about treatments for four conditions that have little or no chance of recovery are:

Treatment Choices for Conditions that Have Little or No Chance of Recovery

*Checking "Yes" means I WANT the treatment for the condition listed.
Checking "No" means I DO NOT WANT treatment for the condition listed.*

<u>Illnesses/Conditions</u>	CPR Heart/Lung Resuscitation		Life Support (by Machines)		Surgery/Blood/Antibiotics/Lab Studies		Tube Feeding by Vein or Stomach	
End-Stage Disease:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Permanent Unconscious State:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Permanent Confusion:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Total Dependence:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other Instructions: _____

Should I meet medical criteria, I do ____ I do not ____ wish to donate my organs and/or tissues for the benefit of others.

Choice of Surrogate for Health Care Affairs

When I am unable to express my own choices or provide consent to withhold or discontinue life-prolonging medical treatment, I appoint the following person(s) to make treatment choices for me consistent with the spirit of this document and my previous expressed choices:

Designate _____
 Tel. No. (_____) _____ Address _____

Alternate *(if Designate not available)* _____
 Tel. No. (_____) _____ Address _____

I hereby hold harmless my physicians and any other health care providers who render care or withhold treatment from me in good faith, if they reasonably believe such action(s) is/are consistent with my wishes. I further request that my family and anyone acting on my behalf follow my wishes and directives and take whatever steps are necessary, including legal action, to ensure that my wishes and directives are carried out. I direct my Power of Attorney or Trustee holding funds on my behalf to make such funds available to my health care surrogate or anyone acting on my behalf to ensure that my wishes, as expressed herein, are carried out.

Print Your Name _____ **Signature** _____
 Social Security No. _____ - _____ - _____ Tel. No. (_____) _____ Date _____
 Address _____

Witness: Print Name _____ **Signature** _____
 Address _____

Witness: Print Name _____ **Signature** _____
 Address _____

(Health care surrogates may NOT serve as witness to this document. One witness should NOT be your spouse or blood relative.)