LIVING WILL ADVANCED DIRECTIVE

INSTRUCTIONS

Part One. Designation of Health Care Surrogate

PRINT YOUR NAME

Name: _____
(Last) (First) (Middle Initial)

In the event that I have been determined to be incapacitated and unable to provide informed consent for medical treatment or surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR SURROGATE

Name: _____

Address: _____

_____ Zip Code: _____

Phone: _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE SURROGATE

Name: _____

Address: _____

_____ Zip Code: _____

Phone: _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

When making health care decisions for me, my health care surrogate should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in Part Three, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care surrogate should make decisions for me that my health care surrogate believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

With regard to Part Two, Companion Animal Declaration, my health care surrogate shall comply fully with my wishes and assignments as stated in this document.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT OR YOUR PET'S CONTINUED CARE BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

NAME ADDRESS AND CONTACT INFORMATION FOR PET(S) APPOINTED GUARDIAN

Additional instructions (optional)

Part Two. Companion Animal Declaration

I have a companion animal(s), pet(s) at home that need care.

Pet's name:_____Species: _____
(Canine, feline, avian, etc.)

Breed: _____ Age: _____Weight: _____

Veterinarian: _____

Address: _____

_____ Zip Code: _____

Phone: _____

Please describe any special needs your pet(s) have, medical etc.: likes, dislikes, habits e.g.: walks, toys, dog parks, friends, treats, sleeping arrangements, food - anything that will make your pet's transition comfortable. Attach additional sheets as required and make separate pages for each pet in your household.

_____

_____

_____

_____

_____

_____

_____

I have appointed _____
(Name of individual or organization designated as the pet's guardian)

Address: _____

_____ Zip Code: _____

Phone: _____

LIVING WILL ADVANCED DIRECTIVE

Additional instructions continued

INSTRUCTIONS

CHECK ONE

NAME OF FUNERAL HOME OR OTHER ENTITY CHARGED WITH RESPONSIBILITY FOR PET(S) FINAL ARRANGEMENTS

PRINT YOUR NAME

DECLARATION OF FINANCIAL COMMITMENT

PRINT NAME OF INSTITUTION HOLDING FUNDS AND CONTACT INFORMATION OF PERSON AUTHORIZED TO RELEASE FUNDS

SIGN AND DATE

INSERT PET'S PHOTO

ADD ANEW PAGE FOR EACH PET

I have made final arrangements for my pet(s) for:

_____ burial

_____ cremation

with _____

(Name of consignee for pet(s) remains e.g. person(s), funeral home, cemetery)

Address: _____

_____ Zip Code: _____

Phone: _____Contract #_____

I, _____,understand that my pet(s) will be cared for by their designated guardian (see page two) for the remainder of their natural life and will not be prematurely euthanized. I have set aside funds in the amount of $_____ to provide for my pet's care. Those funds to be transferred to the above named guardian immediately upon my death or in the event that I am no longer able to provide for my pet's care. These funds are currently held in trust with:

_____

(Name of institution e.g. bank, law firm, etc.)

Address: _____

_____ Zip Code: _____

Phone: _____Contact:_____

Signed: _____ Date:____/____/_____

(day) (month) (year)

RECENT PHOTO OF YOUR PET

INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

INITIAL EACH THAT APPLIES

Part Three. My Health Care Declaration

Declaration made this _____ day of _____, _____,
(day) (month) (year)

I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that:

If at any time I am incapacitated and

(initial all that apply)

_____ I have a terminal condition, or

_____ I have an end-stage condition, or

_____ I am in a persistent vegetative state

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

LIVING WILL ADVANCED DIRECTIVE

Human Organ Tissue Donation (Optional)

INSTRUCTIONS

ORGAN DONATION (OPTIONAL)

INITIAL ONLY ONE OF THE FOUR OPTIONS

IF YOU HAVE ALREADY ARRANGED TO DONATE YOUR ORGANS TO A SPECIFIC DONEE, INITIAL THIS OPTION, AND INDICATE THE DETAILS OF YOUR ARRANGEMENT HERE

I hereby make this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give (initial one choice below):

_____ any needed organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education;

_____ only the following organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education:

_____

_____

_____

_____ my body for anatomical study if needed. Limitations or special wishes, if any:

_____ I have already arranged to donate

_____ Any needed organs, tissues, or eyes,

_____ The following organs, tissues, or eyes:

_____

_____

_____

To the following donee:_____

Phone: _____

Address: _____

_____ Zip Code _____

LIVING WILL ADVANCED DIRECTIVE

INSTRUCTION

PRINT YOUR NAME

SIGN AND DATE THE DOCUMENT

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

PRINT THE NAMES AND ADDRESSES OF THOSE WHO YOU WANT TO KEEP COPIES OF THIS DOCUMENT DISTRIBUTE COPIES TO RELATIVES, FRIENDS, PHYSICIAN, VETERINARIAN, COWORKERS, HEALTHCARE PROVIDERS INCLUDING ANY ENTITY NAMED IN THE DOCUMENT

LAST STEP, LET OTHERS KNOW WHERE TO FIND IT

Part Four. Execution

I, _____, understand the full affect of this declaration, and I am emotionally and mentally competent to make this declaration. I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

Signed: _____

Date: _____

Witness 1:

Signed: _____

Address: _____

_____

Witness 2:

Signed: _____

Address: _____

_____

I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is and what are my exact wishes.

Name: _____

Address: _____

_____

Name: _____

Address: _____

_____

Name: _____

Address: _____

_____

I HAVE PLACED A COPY OF THIS DOCUMENT IN THE FOLLOWING LOCATION:

MY HOME AT _____

IN (DESCRIBE IN DETAIL WHERE IT CAN BE FOUND) _____

_____

_____