Advance Directive for Life-Sustaining Treatment

1. Personal Information

Name: _____

Date of Birth: _____

Address: _____

2. Statement of Intent

This advance directive reflects my wishes concerning life-sustaining treatment should I be diagnosed with a terminal condition or be in a permanent unconscious state and unable to communicate my wishes.

3. Instructions for Life-Sustaining Treatment

Please indicate your preferences regarding the following treatments:

- ☐ CPR (Cardiopulmonary Resuscitation)
- ☐ Artificial Ventilation
- ☐ Artificial Nutrition and Hydration
- ☐ Dialysis
- ☐ Other (specify): _____

4. Additional Instructions or Comments

_____

_____

_____

5. Health Care Agent (Optional)

Name: _____

Phone: _____

Signature of Person Completing Directive:

_____

Date: _____
Printed Name:

_____

Witnesses

Signature:

_____

Name (printed): _____
Signature:

_____

Name (printed): _____