Advance Healthcare Directive

This form allows you to state your preferences for medical care and to appoint an agent to make healthcare decisions for you in the event you are unable to do so.

Personal Information

Full Name

Date of Birth

Address

Part 1: Power of Attorney for Healthcare

Name of Healthcare Agent

Phone Number

Agent's Address

Alternate Agent (optional)

Part 2: Instructions for Health Care

End-of-Life Decisions

State your preferences for end-of-life care, such as life-sustaining treatment, pain management, organ donation, etc.

Part 3: Additional Instructions

Other Wishes

List other healthcare instructions or wishes. (Optional)

Signatures

Signature of Declarant

Date

Witnesses

This document must be signed by two qualified witnesses or notarized.

Witness #1 Signature

Date

Witness #2 Signature

Date