Advance Medical Decision Directive

Instructions: Complete this form to set forth your wishes regarding medical treatment in the event you are unable to make your own decisions.

Full Name:

_____

Date of Birth:

_____

Address:

_____

1. Health Care Agent (if any)

Name of Agent:

_____

Phone Number:

_____

Relationship to Principal:

_____

Alternate Agent (if any):

_____

2. Treatment Preferences

In the event I have a terminal condition or am permanently unconscious and cannot express my wishes, I direct the following:

☐ I DO want life-sustaining treatment ☐ I DO NOT want life-sustaining treatment

Other wishes regarding pain relief, nutrition, hydration, or other treatments:

3. Additional Instructions

Other directives or wishes:

4. Organ Donation

☐ I elect to donate organs/tissues ☐ I do NOT elect to donate organs/tissues

If yes, limitations or specifics (if any):

Signature of Principal:

Date:

Witness Signature:

Date:

Witness Signature:

Date:

This document is not a substitute for legal advice. Consult an attorney for guidance specific to your situation and jurisdiction.