

Advance Health Care Directive

This is an important legal document. Before signing this document, you should know these important facts:

- This document gives you the right to name another person to make health care decisions for you if you are unable to make those decisions yourself.
- You may specify your wishes regarding health care.
- You may cancel or change this directive at any time.

1. My Information

Name:

Date of Birth:

Address:

Phone Number:

2. Health Care Agent

I appoint the following person as my agent to make health care decisions for me if I am not able to do so:

Agent's Name:

Relationship to Me:

Phone Number:

Alternate Agent (optional):

3. Health Care Instructions

If I become unable to make my own health care decisions, my wishes regarding medical treatment are as follows (you may add attachments if desired):

4. Organ & Tissue Donation (Optional)

5. Signature

Signature:

Date:

6. Witnesses

This document must be signed by two adult witnesses or a notary public:

Witness #1 Name:

Witness #1 Signature:

Witness #2 Name:

Witness #2 Signature:
