PRINT THE NAME, RELATIONSHIP, ADDRESS, PHONE NUMBER AND EMAIL ADDRESS OF YOUR AGENT

APPOINTMENT OF HEALTH CARE AGENT

Health care agent:

____
(Name and relationship)
Address: ____
Telephone Number: Home ___________________ Work _________________
Email: ____

IF YOU DO NOT NAME A HEALTH CARE AGENT, HEALTH CARE PROVIDERS WILL ASK YOUR FAMILY OR AN ADULT WHO KNOWS YOUR PREFERENCES AND VALUES FOR HELP IN DETERMINING YOUR WISHES FOR TREATMENT.

NOTE THAT YOU MAY NOT APPOINT YOUR DOCTOR OR OTHER HEALTH CARE PROVIDER AS YOUR HEALTH CARE AGENT UNLESS RELATED TO YOU BY BLOOD, MARRIAGE, OR ADOPTION.

If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named. (It is helpful, but not required, to name alternative health care agents.)

PRINT THE NAME, RELATIONSHIP, ADDRESS, PHONE NUMBER AND EMAIL ADDRESS OF YOUR ALTERNATE HEALTH CARE AGENTS

First Alternative Health Care Agent:

____
(Name and relationship)
Address: ____
Telephone Number: Home ___________________ Work _________________
Email: ____

Second Alternative Health Care Agent:

____
(Name and relationship)
Address: ____
Telephone Number: Home ___________________ Work _________________
Email: ____

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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, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES, IF NEEDED

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GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL)

When making health care decisions for me, my health care agent should think about what actions would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other document, 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 agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

I offer the following instructions as additional guidance to my health care agent: ____

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LIVING WILL INFORMATION

CROSS OUT ANY TREATMENT INSTRUCTIONS WITH WHICH YOU DISAGREE

WRITE "I DO WANT" IF YOU WISH TO RECEIVE THESE TREATMENTS

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PART III: LIVING WILL

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make or communicate my treatment decisions:

IF I HAVE AN END-STAGE MEDICAL CONDITION (WHICH WILL RESULT IN MY DEATH, DESPITE THE INTRODUCTION OR CONTINUATION OF MEDICAL TREATMENT) OR AM PERMANENTLY UNCONSCIOUS SUCH AS AN IRREVERSIBLE COMA OR AN IRREVERSIBLE VEGETATIVE STATE AND THERE IS NO REALISTIC HOPE OF SIGNIFICANT RECOVERY, ALL OF THE FOLLOWING APPLY (CROSS OUT ANY TREATMENT INSTRUCTIONS WITH WHICH YOU DO NOT AGREE)

1. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing or be habit forming.

2. I direct that all life prolonging procedures be withheld or withdrawn. You may want to consult with your physician and attorney in order to determine whether your designated choices regarding end-of-life care are compatible with anatomical donation. In order to donate an organ your body may need to be maintained on artificial support after you have been declared dead to facilitate anatomical donation. Detailed information about the procedures for being declared brain dead or dead by lack of cardiac function and information about organ donation can be found on the Department of Transportation's publicly accessible Internet website.

3. I specifically do not want any of the following as life prolonging procedures: (If you wish to receive any of these treatments, write "I do want" after the treatment)

Heart-lung resuscitation (CPR) _______________
Mechanical ventilator (breathing machine) _______________
Dialysis (kidney machine) _______________
Surgery _______________
Chemotherapy _______________
Radiation treatment _______________
Antibiotics _______________

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries, or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery.

TUBE FEEDINGS

INITIAL ONLY ONE

_____ I want tube feedings to be given

OR

_____ I do not want tube feedings to be given

CROSS OUT ANY TREATMENT INSTRUCTIONS WITH WHICH YOU DISAGREE

4. If I have authorized donation of an organ (such as a heart, liver or lung) or a vascularized composite allograft in the next section of this document, I authorize the use of artificial support, including a ventilator, for a limited period of time after I am declared dead to facilitate the donation.

5. I specifically do not want to be on artificial support after I am declared dead

HEALTH CARE AGENT'S USE OF INSTRUCTIONS

INITIAL ONLY ONE

_____ My health care agent must follow these instructions

OR

_____ These instructions are only guidance. My health care agent shall have final say and may override any of my instructions (indicate any exceptions here): ____

____

____

____

If I have not appointed a health care agent, these instructions shall be followed.

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LEGAL PROTECTION

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions

SIGN AND DATE

Signature: ________________________

Date: ____________________________

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INFORMATION ABOUT ANATOMICAL DONATION

INFORMATION ABOUT ANATOMICAL DONATION

Donating an organ or other part of the body is a voluntary act. Under Pennsylvania law, you do not have to donate an organ or any other part of your body. It is important to know the effect of organ donation on your decisions about end-of-life care so that your wishes about end-of-life care will be fulfilled. If someone wishes to become an organ donor, the person may be kept on artificial support after the person has been declared dead to facilitate anatomical donation. Detailed information about the procedure for recovering organs and other parts of the body and detailed information about brain death and cardiac death may be found on the Department of Transportation's publicly accessible Internet website.

Under Pennsylvania law, the organ donor designation on the driver's license authorizes the individual to donate what we traditionally think of as organs (for example, hear, lung, liver, kidney) and tissue and does not authorize the individual to donate hands, facial tissue, limbs or other vascularized composite allografts.

Under Pennsylvania law, explicit and specific consent to donate hands, facial tissue, limbs and other vascularized composite allografts is needed. Donation of these parts of the body is voluntary. Information about the procedure to transplant hands, facial tissue and limbs can be found on the Department of Transportation's publicly accessible Internet website. It is important to know that donating a hand, limb or facial tissue may impact funeral arrangements and that an open casket may not be possible.

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ORGAN DONATION

ORGAN DONATION

I consent to making an anatomical gift. This does not include hands, facial tissue, limb or other vascularized composite allograft, there is another place in this document for me to do so. I also understand the hospital may provide artificial support, which may include a ventilator, after I am declared dead in order to facilitate donation. I consent to making a gift of the following parts of my body for transplantation or research (please insert any limitations you desire on donation of specific organs or tissues or eyes or any limitation on the use of a donated part of the body):

INCLUDE ANY SPECIFIC INSTRUCTIONS OR LIMITATIONS REGARDING ORGAN DONATION

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SIGN AND DATE IF YOU CHOOSE TO CONSENT TO THIS PROVISION

Signature: _________________________

Date: _____________________________

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INCLUDE ANY LIMITATIONS YOU DESIRE REGARDING DONATION OF HANDS, FACIAL TISSUE, LIMBS OR OTHER VASCULARIZED COMPOSITE ALLOGRAPHS

GIFT OF HANDS, FACIAL TISSUE, LIMBS AND OTHER VASCULARIZED COMPOSITE ALLOGRAFTS

I consent to making a gift of my hands, facial tissue, limbs or other vascularized composite allografts. I also understand that I have the option of requesting reconstructions of my body in preparation for burial and that anonymity of identity may not be able to be protected in the case of donation of hands, facial tissue or limbs. I also understand that burial arrangements may be affected and that an open casket may not be possible. I also understand that the hospital may provide artificial support, which may include a ventilator, after I am declared dead in order to facilitate donation.

Please insert any limitations you desire on donation of hands, facial tissue, limbs or other vascularized composite allografts and whether you request reconstructive surgery before burial:

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SIGN AND DATE IF YOU CHOOSE TO CONSENT TO THIS PROVISION

Signature: __________________________

Date: ______________________________

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PRINT YOUR NAME AND THE DATE AND SIGN HERE

REFUSAL TO DONATE ANY PART OF BODY

I do not consent to donating my organs, tissues or any other part of my body, including hands, facial tissue, limbs or other vascularized composite allografts. This provision serves as a refusal to donate any part of my body. This provision also serves as revocation of any prior decision I have made to donate organs, tissues or other parts of my body, including hands, facial tissue, limbs or other vascularized composite allograft made in a prior document, including a driver's license, will, power of attorney, health care power of attorney or other document.

YOUR TWO WITNESSES MUST SIGN AND DATE AND PRINT THEIR NAMES HERE

Signature: ________________________

Date: ____________________________

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REFUSAL TO DONATE ANY PART OF BODY

SIGN AND DATE IF YOU CHOOSE TO REFUSE TO DONATE ANY PART OF YOUR BODY

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PART IV: SIGNATURE

I, ____ (print your name), having carefully read this document, have signed it this _____ day of ____________, 20_____, revoking all previous health care powers of attorney and health care treatment instructions.

____
(SIGN FULL NAME HERE FOR HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE TREATMENT INSTRUCTIONS)

WITNESS SIGNATURE: ____________________________ Date: _______

Printed name: ____________________________________

WITNESS SIGNATURE: ____________________________ Date: _______

Printed name: ____________________________________

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)