INSTRUCTIONS

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR PRIMARY AGENT

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following person as my agent to make health-care decisions for me:

_____
(name of agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

If I revoke the authority of my agent or if my agent is not willing, able, or reasonably available to make health-care decisions for me, I designate as my first alternate agent:

_____
(name of first alternate agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR SECOND ALTERNATE AGENT

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health-care decision for me, I designate as my second alternate:

_____

(name of second alternate agent)

_____

(address)

_____

(city) (state) (zip code)

_____

(home phone) (work phone)

ADD PERSONAL INSTRUCTIONS UNDER PARAGRAPH (2) ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

(2) AGENT'S AUTHORITY: If I am NOT terminally ill or permanently unconsciousness, my agent is authorized to make all health-care decisions for me, except decisions about life-sustaining procedures and as I state here:

_____

_____

_____

_____

_____

_____

and if I am terminally ill or permanently unconsciousness, my agent is authorized to make all health-care decisions for me, except as I state here:

_____

_____

_____

_____

_____

_____

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I lack the capacity to make my own health-care decisions. As to decisions concerning providing, withholding, and withdrawal of life-sustaining procedures, my agent's authority becomes effective when my primary physician determines I lack the capacity to make my own health-care decisions and my primary physician and another physician determine I am in a terminal condition or permanently unconscious.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

INITIAL THE STATEMENT THAT BEST REFLECTS YOUR WISHES REGARDING NOMINATION OF A GUARDIAN

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court:

_____I nominate the agent(s) whom I named in this form in the order designated to act as guardian.

_____ I nominate the following to be guardians in the order designated:

_____

_____

_____ I do not nominate anyone to be guardian.

PART 2
INSTRUCTIONS FOR HEALTH CARE

(6) END-OF-LIFE DECISIONS: If I can no longer make my own decisions and I have a qualifying condition, I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

IF PARAGRAPH (A) REFLECTS YOUR WISHES, INITIAL ONLY THAT STATEMENT

A. Choice To Prolong Life:

_____ I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

IF PARAGRAPH (B) REFLECTS YOUR WISHES, INITIAL THAT STATEMENT AND ALL OF THE STATEMENTS THAT REFLECT YOUR WISHES, INCLUDING YOUR WISHES ABOUT ARTIFICIAL NUTRITION AND HYDRATION

B. Choice NOT To Prolong Life:

_____ I do not want my life to be prolonged if I have a terminal condition (an incurable condition caused by injury, disease or illness which to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life sustaining procedures, there can be no recovery.) I make the following instructions regarding artificial nutrition and hydration if I have a terminal condition:

Artificial Nutrition through a conduit:
_____ I want _____ I do not want

Artificial Hydration through a conduit:
_____ I want _____ I do not want

ARTIFICIAL NUTRITION OR HYDRATION TROUGH A CONDUIT MEANS NUTRITION OR HYDRATION PROVIDED BY MEANS OF A FEEDING TUBE OR INTRAVENOUS LINE

_____ I do not want my life to be prolonged if I become permanently unconscious (a medical condition that has been diagnosed in accordance with currently accepted medical standards that has lasted at least 4 weeks and with reasonable medical certainty as total irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma.) I make the following instructions regarding artificial nutrition and hydration if I become permanently unconscious:

Artificial Nutrition through a conduit:
_____ I want _____ I do not want

Artificial Hydration through a conduit:
_____ I want _____ I do not want

ADD PERSONAL INSTRUCTIONS UNDER PARAGRAPH (7) ONLY IF YOU WANT TO LIMIT PAIN OR COMFORT TREATMENT

(7) RELIEF FROM PAIN OR DISCOMFORT: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

(8) OTHER HEALTH-CARE INSTRUCTIONS OR WISHES:

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

(add additional pages if needed)

INITIAL THE STATEMENT(S) THAT REFLECT YOUR WISHES REGARDING ORGAN DONATION (OPTIONAL)

PART 3
ANATOMICAL GIFTS AT DEATH (OPTIONAL)

(9) I am mentally competent and 18 years or more of age. I hereby make this anatomical gift to take effect upon my death. The marks in the appropriate lines and words filled into the blanks below indicate my desires.

I give:

_____ My body

_____ any needed organs or parts

_____ the following organ parts:_____

To the following person or institutions:

_____ the physician in attendance at my death

_____ the hospital at which I die

_____ the following named physician, hospital storage bank or medical institution:_____

_____ the following individual for treatment:_____

For the following purposes:

_____ any purpose authorized by law

_____ transplantation

_____ therapy

_____ research

_____ medical education

PROVIDE THE NAME, ADDRESS, AND PHONE NUMBER OF A PHYSICIAN, IF ANY, YOU WOULD LIKE TO HAVE PRIMARY RESPONSIBILITY FOR YOUR HEALTH CARE (OPTIONAL)

PART 4
DESIGNATION OF PRIMARY PHYSICIAN (OPTIONAL)

(10) I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

(11) EFFECT OF COPY: A copy of this form has the same effect as the original.

(12) SIGNATURE: Sign and date the form here:

I understand the purpose and effect of this document.

DATE AND SIGN THE DOCUMENT

_____

(Date) (Sign your name)

PRINT YOUR NAME AND ADDRESS

_____

(Print your name)

_____

(Address)

_____

(City) (State) (Zip code)

YOUR WITNESSES MUST READ THIS STATEMENT AND SIGN ON THE NEXT PAGE

(13) STATEMENT OF WITNESSES

SIGNED AND DECLARED by the above named-declarant as and for his/her written declaration under 16 Del.C. §§2502 and 2503, in our presence, who in his/her presence, at his/her request, and in the presence of each other, have hereunto subscribed our names as witnesses and state:

A. That the declarant is mentally competent.

B. That neither of us:

1. Is related to the declarant by blood marriage or adoption;
2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of executing of the advance health-care directive, is so entitled by operation of law then existing;
3. Has, at the time of the execution of the advance health-care directive, a present or inchoate claim against any portion of the estate of the declarant;
4. Has direct financial responsibility for the declarant's medical care;
5. Has a controlling interest in or is an operator or employee of a health-care institution in which the declarant is a resident or patient; or
6. Is under eighteen years of age.

(IF YOU ARE A RESIDENT OF A NURSING HOME, A REGISTERED PATIENT ADVOCATE OR OMBUDSMAN MUST SERVE AS ONE OF YOUR WITNESSES AND PRINT HIS/HER NAME IN PARAGRAPH C)

C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses, _____, is at the time of the execution of the advance health-care directive a patient advocate or ombudsman designated by the Department of Health and Social Services.

HAVE YOUR WITNESSES SIGN AND DATE THE DOCUMENT, AND THEN PRINT THEIR NAMES AND ADDRESS

Witness 1:

_____
(Date) (Sign your name)

_____
(Print your name)

_____
(Address)

_____
(City) (State) (Zip code)

Witness 2:

_____
(Date) (Sign your name)

_____
(Print your name)

_____
(Address)

_____
(City) (State) (Zip code)

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898