ADVANCE HEALTH CARE DIRECTIVE

I, _____, Date of Birth: ___ / ___ / _____ ,
being of sound mind and at least 18 years of age, declare that:

(1) END-OF-LIFE DECISIONS: If (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, or (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, then I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice(s) I have marked below: (Mark one main choice and exceptions only if desired.)

[___] Choice NOT To Prolong Life. I do not want my life to be prolonged.

OR

[___] Choice TO Prolong Life. I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

EXCEPTIONS: I would NOT want these interventions:

(___) blood or blood products
(___) surgery or invasive diagnostic tests
(___) kidney dialysis
(___) antibiotics
(___) cardiac resuscitation
(___) mechanical respiration
(___) tube feeding
(___) intravenous hydration

Additional Comments and Clarification (Optional)

(2) RELIEF FROM PAIN: My choice above does not limit my providers from administering appropriate pain relief.

(3) DONATION OF ORGANS AT DEATH: (OPTIONAL) (Mark applicable box.)

[___] I consent to donate my organs and tissues at the time of death for the purpose of transplant, medical study or education.

OR

[___] I do not consent to donate my organs or tissues at the time of my death

(4) HEALTH CARE AGENT: I appoint the following health care agent to act as my durable power of attorney for health care:

Name: _____ Relationship: _____
Address: _____
Telephone Number – Home: _____ Work: _____

ALTERNATE Health Care Agent (if the above-named agent is unavailable):

Name: _____ Relationship: _____
Address: _____
Telephone Number – Home: _____ Work: _____

I execute this declaration, as my free and voluntary act, on this _____ day of _____, 20__, in the City of_____, County of _____, State of _____.

_____

(Sign Full Name here for all four provisions above.)

(5) WITNESSES: 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.)

_____

_____

(signature, name and address of first witness)

_____

_____

(signature, name and address of second witness)

(6) NOTARY (OPTIONAL): On this the _____ day of _____, 20__, before me, the undersigned, a notary public in and for said County and State, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal. _____

Signature of Notary