Last Name: _____

First Name: _____

DOB:

BAYVIEW

ADVANCED MEDICAL DIRECTIVE

This form contains a "Living Will" section , and a "Durable Medical Power of Attorney" section. You may complete any or all sections of this form. Please cross out any section you do not use. You must sign the form at the bottom in the presence of two witnesses who are not blood relatives, or your spouse. Your witnesses also need to sign. Copies should be given to your attending physician, relatives and appointed agents. Your directives can be cancelled or changed at any time, but you should make every attempt to destroy all of the old copies and distribute new ones as appropriate.

Living Will

made this day on _____ (date)

I, _____, willfully and voluntarily make known my desires and do hereby declare:
If at any time my attending physician should determine that I have a terminal condition or when medical treatment is futile, and the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that life-prolonging procedures (CPR, intubation/ventilation. Artificial nutrition, artificial hydration) be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

OPTION: I specifically direct that the following procedures or treatments be provided to me: _____

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal. This advance directive shall not terminate in the event of my disability. By signing below, I indicate that I understand the purpose and effect of the document.

Durable Medical Power of Attorney

made this day on _____ (date)

I, _____, hereby grant my agent(s), named below, full power and authority to make health care decisions on my behalf as directed, whenever I have been determined to be incapable of making an informed decision about providing, withholding, or withdrawing medical treatment. I hereby appoint the following as my agent(s) to make decisions on my behalf as authorized in this document.

_____

Primary Agent | Relationship | Phone Number

If the above named primary agent is not reasonably available or is unable or unwilling to act as my agent, I then appoint the following secondary agent to serve in that capacity:

_____

Secondary Agent | Relationship | Phone Number

This Advanced Directive shall not terminate in the event of my disability. By signing below, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand the purpose and effect of this document.

Signed: _____ Date: _____

The Declarant signed the forging Advanced Directive in my presence. I am not the spouse of a blood relative of the Declarant.

Witness # 1: Signed: _____ Date: _____

Witness # 2: Signed: _____ Date: _____