THESE ARE MY HEALTH CARE INSTRUCTIONS. MY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE, THE DESIGNATION OF MY CONSERVATOR OF THE PERSON FOR MY FUTURE INCAPACITY AND MY DOCUMENT OF ANATOMICAL GIFT

To any physician who is treating me: These are my health care instructions including those concerning the withholding or withdrawal of life support systems, together with the appointment of my health care representative, the designation of my conservator of the person for future incapacity and my document of anatomical gift. As my physician, you may rely on these health care instructions and any decision made by my health care representative or conservator of my person, if I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care.

I, _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment. The life support systems which I do not want include, but are not limited to: Artificial respiration, cardiopulmonary resuscitation and artificial means of providing nutrition and hydration. I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

I appoint _____ to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, my health care representative is authorized to make any and all health care decisions for me, including (1) the decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, including, but not limited to,such as for psychosurgery or shock therapy, as defined in section 17a-540, and (2) the decision to provide, withhold or withdraw life support systems. I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

If _____is unwilling or unable to serve as my health care representative, I appoint _____ to be my alternative health care representative.

If a conservator of my person should need to be appointed, I designate _____ be appointed my conservator. If _____ is unwilling or unable to serve as my conservator, I designate _____. I designate _____to be successor conservator. No bond shall be required of either of them in any jurisdiction.

I hereby make this anatomical gift, if medically acceptable, to take effect upon my death.

I give: (check one)

_____ (1) any needed organs or parts

_____ (2) only the following organs or parts _____

to be donated for: (check one)

(1) _____ any of the purposes stated in subsection (a) of section 11 of this act.

(2) _____ these limited purposes _____.

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

Date _____, 20_____

_____ L. S.

This document was signed in our presence by _____, the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

_____	_____
(Witness)	(Witness)
_____	_____
(Number and Street)	(Number and Street)
_____	_____
(City, State and Zip Code)	(City, State and Zip Code)

STATE OF CONNECTICUT }
} ss_____
COUNTY OF _____}

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointments of a health care representative, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request, and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20_____.

_____ _____
(Witness) (Witness)

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____
Commissioner of the Superior Court
Notary Public
My commission expires: _____

(Print or type name of all persons signing under all signatures)