FREEMAN Health System

Advance Medical Directive Form
(Living Will – Part I)

* A M D *

NOTE: This is a two part form. You may complete both parts or only one part.

Part I: Health Care Treatment Directive DOB: _____/_____/_____

I, _____, make this Health Care Directive to exercise my right to determine the course of my health care and to provide clear and convincing proof of my treatment decisions when I lack the capacity to make or communicate my decisions.

If my physician believes that a certain life-prolonging procedure or other health care treatment may provide me with comfort, relieve pain or lead to significant recovery, I direct my physician to try the treatment for a reasonable period of time. However, if such treatment proves to be ineffective, I direct the treatment to be withdrawn, even if doing so may shorten my life.

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

2) I direct all life prolonging procedures to be withheld or withdrawn when there is no realistic hope of significant recovery if I have a terminal condition or if I have any of the following conditions: (check all that apply)

   - ☐ a condition, disease or injury without hope of significant recovery and there is no reasonable expectation that I will regain an acceptable quality of life; or
   - ☐ severe brain damage or brain disease which cannot be significantly reversed

3) When the above conditions exist, I choose to have the following life-prolonging procedures withheld or withdrawn: (check all that apply)

   - ☐ Surgery or other invasive procedure
   - ☐ Dialysis
   - ☐ Heart-lung resuscitation (CPR)
   - ☐ Mechanical ventilator (respirator)
   - ☐ Artificially supplied nutrition and hydration (including tube feeding of food and water)
   - ☐ Medications other than those that provide comfort

4) I make other instructions as follows: _____
   _____

Signed this _____ day of _____
(month, year)

Signed _____ _____
(signature) (city, county and state of residence)

The Declarant is known to me, is 18 years of age or older, is of sound mind and has voluntarily signed this document. {Note: If the Declarant is unable to sign, then this document may be signed by another person in the Declarant's presence at the Declarant's expressed direction. This Part I is effective with two witnesses who must be over the age of 18 and who cannot be the same person who signs for the Declarant if someone does. No notary is needed.}

Witness _____ Address _____

Witness _____ Address _____

(see other side for Part II)

Advance Medical Directive Form
(Power of Attorney – Part II)

NOTE: This is a two part form. You may complete both parts or only one part.

Part II: Durable Power of Attorney for Health Care Decisions DOB: _____/_____/_____

I, _____, hereby appoint _____
(name of Declarant) (name of Agent)

of _____, phone number _____
(Agent's address) (Agent's phone number)

as my Agent to make health care decisions for me if and when I am unable to make my own health care decisions due to incapacity. This gives my Agent the power to consent to giving, withholding or stopping any health care, treatment, service or diagnostic procedure. In exercising this authority, my Agent should follow my desires as stated in my Health Care Treatment Directive (if I have issued one) or as otherwise known to my Agent. If the person named as my Agent is not available or is unable to act as my Agent, then I appoint: _____ of _____,
(name of alternate Agent) (alternate Agent's address)
phone number _____ with the like power to act in my Agent's place instead.
(alternate Agent's phone number)

THIS IS A DURABLE POWER OF ATTORNEY AND THE AUTHORITY OF MY AGENT SHALL NOT TERMINATE IF I BECOME DISABLED OR INCAPACITATED OR IN THE EVENT OF LATER UNCERTAINTY AS TO WHETHER I AM DEAD OR ALIVE.

Signed this _____ day of _____
(month, year)

Signed _____ _____
(Signature) (City, County and State of Residence)

TO BE COMPLETED BY A NOTARY PUBLIC
(This Part II must be notarized.)

STATE OF MISSOURI)
)
COUNTY OF _____)

On this _____ day of _____, before me personally appeared the Declarant, _____, to me known to be the person described in and who executed the foregoing instrument and acknowledges that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of _____ the day and year first above written.

_____
Notary Public

My Commission expires: _____