ADVANCE DIRECTIVE (Optional Form)

HEALTH CARE INSTRUCTIONS

(If you want to use this form, initial those statements you want to be included in the document and cross through those statements that do not apply.)

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below. (Initial all those that apply).

1. If my death from a terminal condition is imminent, and, even if life-sustaining procedures are used, there is no reasonable expectation of my recovery:

_____I direct my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food and water by mouth, I wish to receive nutrition and hydration artificially.

2. If I am in a persistent vegetative state, that is, if I am not conscious and am not aware of my environment nor able to interact with others, and there is no reasonable expectation of my recovery:

_____I direct that my life not be extended by life-sustaining procedures including the administration of nutrition and hydration artificially.

_____I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food and water by mouth, I wish to receive nutrition and hydration artificially.

3. If I have an end-stage condition, that is, an irreversible condition caused by injury, disease, or illness, as a result of which I have severe and permanent deterioration indicated by incompetency and complete physical dependency and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective:

_____I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food and water by mouth, I wish to receive nutrition and hydration artificially.

4. _____I direct that, no matter what my condition, medication to relieve pain and suffering not be given to me, if it would shorten my remaining life.

5. _____I direct that, no matter what my condition, I be given all available medical treatment in accordance with accepted health care standards.

6. If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

_____
_____
_____

7. I direct (in the following space, indicate any other instructions regarding receipt or non-receipt of any health care).

_____
_____
_____

Signature Of Declarant

By signing below, I indicate that I am emotionally and mentally competent to make these Health Care Instructions and that I understand its purposes and effect.

_____ _____

Signature of Declarant Date

_____

Print Declarant's Name

Witness Statement

The Declarant signed or acknowledged signing these Health Care Instructions in my presence, and based upon my personal observation, the Declarant appears to be a competent individual. I am not the Health Care Agent of the Declarant. At least one of us is an individual who is not knowingly entitled to any portion of the Estate of the Declarant or knowingly entitled to any financial benefits by reason of the death of the Declarant.

_____ _____

First Witness Signature Second Witness Signature

_____ _____

Print Name Print Name

_____ _____

Address Address

_____ _____

City, State, Zip Code City, State, Zip Code