

Advanced Health Care Directive

Some general statements concerning your health care options are outlined below. If you agree with one of the statements, you should initial that statement. Read all of these statements carefully before you initial your selection. You can also write your own statement concerning life-sustaining treatment and other matters relating to your health care.

- _____ 1. I wish to live and enjoy life as long as possible, but I do not wish to receive medical treatment that will provide minimal or no benefit to me and will only secure a precarious prolongation of my life which is burdensome to me. I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits. I want my Agent to consider the relief of my suffering and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment. As a guiding desire, I would, if competent, reject treatments or procedures that impose suffering or strain on me out of proportion to the benefits expected to be gained by their use. Further, I want treatment for alleviation of pain or discomfort to be provided at all times, even if it hastens my death.
- _____ 2. I want efforts made to prolong my life and I want life-sustaining treatment to be provided unless I am in a coma or persistent vegetative state which my doctor reasonably believes to be irreversible. Once my doctor has concluded that I will remain unconscious for the rest of my life, I do not want life-sustaining treatment to be provided or continued.
- _____ 3. I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.
- _____ 4. Notwithstanding my other directions, if I am known to be pregnant, I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.
- _____ 5. I Do / Do Not want to authorize donation of my body or organs for transplant, (please circle the one you want)

First Agent: _____ Address/Phone # _____

Second Agent: _____ Address/Phone # _____

Third Agent: _____ Address/Phone # _____