Colorado Advance Health Care Directive

On this date of _____ , I, _____ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my signature next to the sections of this Directive that I have adopted:

[ ] Living Will (Declaration as to Medical or Surgical Treatment)
[ ] Selection of Health Care Agent (Medical Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will (Declaration as to Medical or Surgical Treatment)

I, being of sound mind and at least eighteen (18) years of age, direct that my life shall not be artificially-prolonged under the circumstances set forth below and hereby declare that:

(1) If at any time my attending physician and one (1) other qualified physician certify in writing that:

(a) I have an injury, disease, or illness which is not curable or reversible and which, in their judgment, is a terminal condition, and

(b) For a period of seven (7) consecutive days or more, I have been unconscious, comatose, or otherwise incompetent so as to be unable to make or communicate responsible decisions concerning my person, then:

I direct that, in accordance with Colorado law, life-sustaining procedures shall be withdrawn and withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nourishment considered necessary by the attending physician to provide comfort or alleviate pain. However, I may specifically direct, in accordance with Colorado law, that artificial nourishment be withdrawn or withheld pursuant to the terms of this declaration.

(2) In the event that the only procedure I am being provided is artificial nourishment, I direct that one of the following actions be taken **(initial your choice)**:

[ ] (a) Artificial nourishment SHALL NOT be continued when it is the only procedure being provided; **OR**

[ ] (b) Artificial nourishment SHALL be continued for _____ days when it is the only procedure being provided; **OR**

[ ] (c) Artificial nourishment SHALL be continued when it is the only procedure being provided.

Selection of Health Care Agent
(Medical Durable Power of Attorney for Health Care)

I hereby appoint _____ (name), of _____ (address), as my agent to make health care decisions for me if and when I am unable to make my own health care decisions. This gives my agent the power to consent to giving, withholding, or stopping any health care, treatment, service, or diagnostic procedure. My agent also has the authority to talk with health care personnel, get information, and sign forms necessary to carry out those decisions.

By this document I intend to create a Medical Durable Power of Attorney which shall take effect upon my incapacity to make my own health care decisions and shall continue during that incapacity. My agent shall make health care decisions as I may direct below or as I make known to him or her in some other way. If I have not expressed a choice about the health care in question, my agent shall base his or her decisions on what he or she believes to be in my best interest.

(1) Statement of desires concerning life-prolonging care, treatment, services, and procedures **(insert your wishes. Attach additional sheets if necessary)**:

(2) Special provisions and limitations **(add any provisions and limitations):**

Designation of Primary Physician

I designate the following physician as my primary physician: _____ (name)
_____ (address)
_____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:
_____ (name)
_____ (address)
_____(phone).

Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes **that I have initialed below:**

[ ] any organs or parts **OR**
[ ] eyes [ ] bone and connective tissue [ ] skin
[ ] heart [ ] kidney(s) [ ] liver
[ ] lung(s) [ ] pancreas [ ] other _____
for the purposes of:
[ ] any purpose authorized by law **OR**
[ ] transplantation [ ] research [ ] therapy
[ ] medical education [ ] other limitations _____

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will (Declaration as to Medical or Surgical Treatment)
[ ] Selection of Health Care Agent (Medical Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature _____ Date _____

City, County, and State of Residence _____

Notary Acknowledgment

State of _____
County of _____
On _____ , _____ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Notary Public
My commission expires _____

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care agent or attorney-in-fact herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

Acceptance of Health Care Agent and Attorney-in-Fact for Health Care

I accept my appointment as Health Care Agent and Attorney-in-Fact for Health Care

Signature _____ Date _____