Connecticut 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 initials next to the sections of this Directive that I have adopted:

[ ] Living Will (Document Concerning Withholding or Withdrawal of Life Support Systems)
[ ] Selection of My Health Care Agent (Attorney-in-Fact for Health Care Decisions)
[ ] Designation of Primary Physician
[ ] Organ Donation

NOTICE TO ANY ATTENDING PHYSICIAN: 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 agent and my attorney-in-fact for health care decisions, the designation of my conservator of the person for future incapacity and my document of anatomical gift. As my physician, you may rely on any decision made by my health care agent, attorney-in-fact for health care decisions or conservator of my person, if I am unable to make a decision for myself.

Living Will (Document Concerning Withholding or Withdrawal of Life Support Systems)

If the time comes when 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 wish this statement to stand as a testament of my wishes.

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.

Selection of My Health Care Agent
(Attorney-in-Fact for Health Care Decisions)

I appoint ____ (name),
of ____ (address),
to be my health care agent and attorney-in-fact for health care decisions. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and am unable to reach and communicate an informed decision regarding treatment, my health care agent and attorney-in-fact for health care decisions is authorized to:

(1) Convey to my physician my wishes concerning the withholding or removal of life support systems;
(2) Take whatever actions are necessary to ensure that any wishes are given effect;
(3) Consent, refuse, or withdraw consent to any medical treatment as long as such action is consistent with my wishes concerning the withholding or removal of life support systems; and
(4) Consent to any medical treatment designed solely for the purpose of maintaining physical comfort.

If the above-appointed person is unable or unwilling to serve, I appoint the following person as my alternative health care agent and attorney-in-fact for health care decisions:
____ (name)
____ (address)

If a conservator of my person should need to be appointed, I designate that the person above whom I have designated as my initial health care agent and attorney-in-fact for health care decisions also be appointed my conservator. If that person is unwilling or unable to serve, I designate the person appointed as my alternative health care agent and attorney-in-fact for health care decisions.

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 t**hat 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 (Document Concerning Withholding or Withdrawal of Life Support Systems)
[ ] Selection of My Health Care Agent (Attorney-in-Fact for Health Care Decisions)
[ ] 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 ____

Witness Acknowledgment

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointments of a health care agent and an attorney-in-fact, the designation of a conservator for future incapacity, the designation of a primary physician, 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 (18) 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. The author has been personally known to us and we believe him or her to be of sound mind. We did not sign the author's signature above for or at the direction of the author

and we are not appointed as the health care agent or attorney-in-fact therein. We are not related to the author by blood, adoption, or marriage, entitled to any portion of the estate of the author according to the laws of intestate succession or under any will of author or codicil thereto, or directly financially responsible for author's medical care.

Witness Signature ______________________________ Date ____________________

Printed Name of Witness __________________________

Second Witness Signature ______________________________ Date ___________________

Printed Name of Second Witness __________________________

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.

Additionally, on the same date and time, the following persons as witnesses subscribed and were sworn to the above witness acknowledgement.

_________________________________, witness

_________________________________, witness

____
Notary Public
My commission expires ____________________

Acceptance of Health Care Agent and Attorney-in-Fact For Health Care Decisions

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

Signature ______________________________ Date ____________________