District of Columbia (Washington D.C.) 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 (Declaration)
[ ] Selection of Health Care Agent (Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will (Declaration)

I, being of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below and do declare: If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two (2) physicians who have personally examined me, one (1) of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.
Other directions **(insert other instructions if desired)**:

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

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

INFORMATION ABOUT THIS DOCUMENT: This is an important legal document. Before signing this document, it is vital for you to know and understand these facts: This document gives the person you name as your attorney-in-fact the power to make health care decisions

for you if you cannot make the decisions for yourself. After you have signed this document, you have the right to make health care decisions for yourself if you are mentally competent to do so. In addition, after you have signed this document, no treatment may be given to you or stopped over your objection if you are mentally competent to make that decision. You may state in this document any type of treatment that you do not desire and any that you want to make sure you receive. You have the right to take away the authority of your attorney-in-fact, unless you have been adjudicated incompetent, by notifying your attorney-in-fact or health care provider either orally or in writing. Should you revoke the authority of your attorney-in-fact, it is advisable to revoke in writing and to place copies of the revocation wherever this document is located. If there is anything in this document that you do not understand, you should ask a social worker, lawyer, or other person to explain it to you. You should keep a copy of this document after you have signed it. Give a copy to the person you name as your attorney-in-fact. If you are in a health care facility, a copy of this document should be included in your medical record.

I hereby appoint ____ (name), of ____(address), as my attorney-in-fact to make health care decisions for me if I become unable to make my own health care decisions. This gives my attorney-in-fact the power to grant, refuse, or withdraw consent on my behalf for any health care service, treatment, or procedure. My attorney-in-fact also has the authority to talk to health care personnel, get information, and sign forms necessary to carry out these decisions.

OPTIONAL - DESIGNATION OF ALTERNATE ATTORNEY-IN FACT FOR HEALTH CARE: If I revoke my attorney-in-fact's authority or if my attorney-in-fact is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate attorney-in-fact for health care.

________________________________ (name of individual you choose as first alternate agent)
____ (address)

With this document, I intend to create a power of attorney for health care, which shall take effect if I become incapable of making my own health care decisions and shall continue during that incapacity. My attorney-in-fact shall make health care decisions as I direct below or as I make known to my attorney-in-fact in some other way.
Statement of directives concerning life-prolonging care, treatment, services and procedures **(insert statement. Attach additional sheets if necessary)**:

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)
[ ] Selection of Health Care Agent (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 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 ____________________

Signature of Alternate_____________________________ Date ____________________