Illinois 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

If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death-delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.
In the absence of my ability to give directions regarding the use of such death-delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

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

NOTICE: The purpose of this power of attorney is to give the person you designate (your "agent") broad powers to make health care decisions for you, including power to require, consent to, or withdraw any type of personal care or medical treatment for any physical or mental condition, and to admit you to or discharge you from any hospital, home, or other institution. This form does not impose a duty on your agent to exercise granted powers; but when powers are exercised, your agent will have to use due care to act for your benefit and in accordance with this form and keep a record of receipts, disbursements, and significant actions taken as agent. A court can take away the powers of your agent if it finds the agent is not acting properly. Unless you expressly limit the duration of this power in the manner provided below, until you revoke this power or a court acting on your behalf terminates it, your agent may exercise the powers given here throughout your lifetime, even after you become disabled. The powers you give your agent, your right to revoke those powers, and the penalties for violating the law are explained more fully in Sections 4-5, 4-6, 4-9, and 4-10[b] of the Illinois "Powers of Attorney for Health Care Law" of which this form is a part. That law expressly permits the use of any different form of power of attorney you may desire. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.

I hereby appoint ____(name), of ____ (address), as my attorney-in-fact (my "agent") to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and health care and to require, withhold, or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to authorize an autopsy and direct the disposition of my remains. Effective upon my death, my agent has the full power to make an anatomical gift of the following:

[   ] Any organ, tissues, or eyes suitable for transplantation or used for research or education

[   ] Specific organs (*list the specific organs*).

(The above grant of power is intended to be as broad as possible so that your agent will have authority to make any decision you could make to obtain or terminate any type of health care, including withdrawal of food and water and other life-sustaining measures, if your agent believes such action would be consistent with your intent and desires. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to make an anatomical gift, authorize autopsy or dispose of remains, you may do so in the following paragraphs.)

The powers granted above shall not include the following powers or shall be subject to the following rules or limitations **(Here you may include any specific limitations you deem appropriate, such as: your own definition of when life-sustaining measures should be withheld; a direction to continue food and fluids or life-sustaining treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electro-convulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc.)**:

The subject of life-sustaining treatment is of particular importance. For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life-sustaining treatment are set forth on the following pages. If you agree with one of these statements, you may initial that statement; but do not initial more than one.

[   ] I do NOT want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

[   ] I DO want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am in a coma which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered irreversible coma, I want life-sustaining treatment to be withheld or discontinued.

[   ] I DO want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures.

This power of attorney may be amended or revoked by you at any time and in any manner while you are able to do so. In the absence of an amendment or revocation, the authority granted in this power of attorney will become effective at the time this power is signed and will continue until your death and will continue beyond your death if anatomical gift, autopsy, or disposition of remains is authorized, unless a limitation on the beginning date or duration is made by initialing and completing either or both of the following:

[ ] This power of attorney shall become effective on ______________________________
(Insert a future date or event during your lifetime, such as court determination of your disability, incapacity, or incompetency, when you want this power to first take effect).

[ ] This power of attorney shall terminate on____________________________________
(Insert a future date or event during your lifetime, such as court determination of your disability, incapacity, or incompetency, when you want this power to terminate prior to your death).

If you wish to name an alternate agent, insert the name and address of such successor in the following paragraph:

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent
________________________________ (name of individual you choose as first alternate agent)
____ (address)

If you wish to name a guardian of your person in the event a court decides that one should be appointed, you may, but are not required to, do so by inserting the name of such guardian in the following paragraph. The court will appoint the person nominated by you if the court finds that such appointment will serve your best interests and welfare. You may, but are not required to, nominate as your guardian the same person named in this form as your agent.

If a guardian of my person is to be appointed, I nominate the following to serve as such guardian:
____ (name of individual you choose as guardian)
____ (address)

I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

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. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he or she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant's signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.

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 ___________________

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

Signature _____________________________ Date ___________________