Indiana 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 or Life-Prolonging Procedures Declaration
[ ] Selection of Health Care Agent (Health Care Representative and Attorney-in-Fact for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will Declaration or Life-Prolonging Procedures Declaration

You may select either a Living Will Declaration OR a Life-Prolonging Procedures Declaration (on next page), but not both.

Living Will Declaration [ ] **(Initial if you choose this option.)**

I, being of sound mind and at least 18 years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare that:

If at any time my attending physician certifies in writing that:

(1) I have an incurable injury, disease, or illness,
(2) my death will occur within a short time, and
(3) the use of life-prolonging 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I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially-supplied nutrition and hydration **(indicate your choice by initialing only one of the following):**

[ ] I DO wish to receive artificially-supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.
[ ] I do NOT wish to receive artificially-supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.
[ ] I intentionally make no decision concerning artificially-supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney-in-fact with health care powers under IC 30-5-5.

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this declaration 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 of the refusal. I understand the full import of this declaration.

OR

Life-prolonging Procedures Declaration [ ] **(Initial if you choose this option.)**
I, being of sound mind and at least 18 years of age, willfully and voluntarily make know my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition, I request the use of life-prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request. I understand the full import of this declaration.

Selection of Health Care Agent (Health Care Representative and Attorney-in-Fact for Health Care)

Under the terms of Indiana Code, Sections 30-5-5 and 16-36-1-7, I hereby appoint:
_____(name),
of _____ (address),
as both my health care representative and my attorney-in-fact for health care to make health care decisions on my behalf whenever I am incapable of making my own health care decisions. I grant my attorney-in-fact the following powers in matters affecting my health care to: (1) employ or contract with servants, companions, or health care providers involved in my health care, (2) admit or release me from a hospital or health care facility, (3) have access to my records, including medical records, (4) make anatomical gifts on my behalf, (5) request an autopsy, and (6) make plans for the disposition of my body.

APPOINTMENT OF MY ATTORNEY-IN-FACT AS MY HEALTH CARE REPRESENTATIVE: In addition to the powers granted above, I appoint my attorney-in-fact as my health care representative to make decisions in my best interest concerning the consent, withdrawal, or withholding of health care. I understand health care to include any medical care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental well-being. Health care also includes the providing of nutrition and hydration. If at any time, based on my previously-expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result. My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others, to the extent they are available.

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 or Life-Prolonging Procedures Declaration
[ ] Selection of Health Care Agent (Health Care Representative and Attorney-in-Fact 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 Representative and Attorney-in-Fact for Health Care

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

Signature _____ Date _____