Kentucky 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 Directive
[ ] Selection of Health Care Agent (Health Care Surrogate)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will Directive

My wishes regarding life-prolonging treatment and artificially-provided nutrition and hydration to be provided to me if I no longer have decisional capacity, have a terminal condition, or become permanently unconscious have been indicated by initialing the appropriate lines below. By *initialing* the appropriate lines, I specifically provide the following directions to my attending physician:
(Initial one)

[ ] I direct that treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain.
[ ] I Do NOT authorize that life-prolonging treatment be withheld or withdrawn.

(Initial one)

[ ] I authorize the withholding or withdrawal of artificially-provided food, water, or other artificially-provided nourishment or fluids.
[ ] I Do NOT authorize the withholding or withdrawal of artificially-provided food, water, or other artificially-provided nourishment or fluids.
[ ] I authorize my health care surrogate, designated on the following page, to withhold or withdraw artificially-provided nourishment or fluids, or other treatment if the surrogate determines that withholding or withdrawing is in my best interest; but I do not mandate that withholding or withdrawing.

In the absence of my ability to give directions regarding the use of life-prolonging treatment and artificially-provided nutrition and hydration, it is my intention that this directive shall be honored by my attending physician, my family, and any surrogate designated pursuant to this directive as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of the refusal. If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.

Selection of Health Care Agent (Health Care Surrogate)

I designate ____ (name), of
____ (address), as
my health care surrogate to make health care decisions for me in accordance with this directive when I no longer have decisional capacity.

OPTIONAL - DESIGNATION OF ALTERNATE SURROGATE: If I revoke my surrogate's authority or if my surrogate is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate health care surrogate
_________________________________ (name of individual you choose as alternate surrogate)
____ (address)

Any prior designation is revoked. If I do not designate a surrogate, the above instructions indicated in my living will are my directions to my attending physician. If I have designated a surrogate, my surrogate shall comply with my wishes as indicated above in my living will.

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 Directive
[ ] Selection of Health Care Agent (Health Care Surrogate)
[ ] 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 (Health Care Surrogate)

I accept my appointment as Health Care Agent (Health Care Surrogate):

Signature _______________________________ Date ____________________

I accept my appointment as Alternate Health Care Agent (Health Care Surrogate):

Signature _______________________________ Date ____________________