Michigan 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 and Directive to Physicians)
[ ] Selection of Health Care Agent (Designation of Patient Advocate for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will (Declaration and Directive to Physicians)

I, willfully and voluntarily, make known my desire that my life not be artificially prolonged under the circumstances set forth below, and, pursuant to any and all applicable laws in the State of Michigan, I declare that:

If at any time I should have an incurable injury, disease, or illness which has been certified as a terminal condition by my attending physician and one (1) additional physician, both of whom have personally examined me, and such physicians have determined that there can be no recovery from such condition and my death is imminent, and where the application 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procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the administration of nutrition, or the performance of any medical procedure deemed necessary to provide me with comfort, care, or to alleviate pain.

If at any time I should have been diagnosed as being in a persistent vegetative state which has been certified as incurable by my attending physician and one (1) additional physician, both of whom have personally examined me, and such physicians have determined that there can be no recovery from such condition, and where the application 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procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the administration of nutrition, or the performance of any medical procedure deemed necessary to provide me with comfort, care, or to alleviate pain.

In the absence of my ability to give directions regarding my treatment in the above situations, including directions regarding the use of such life-prolonging procedures, it is my intention that this Declaration shall be honored by my family, my physician, and any court of law, as the final expression of my legal right to refuse medical and surgical treatment. I declare that I fully accept the consequences for such refusal. If I am diagnosed as pregnant, this document shall have no force and effect during my pregnancy.

I understand the full importance of this Declaration and I am emotionally and mentally competent to make this Declaration and Living Will. No person shall be in any way responsible for the making or placing into effect of this Declaration and Living Will or for carrying out my express directions. I also understand that I may revoke this document at any time.

Selection of Health Care Agent (Designation of Patient Advocate for Health Care)

I am of sound mind, and I voluntarily make this designation. I designate :
_____ (name),
of _____ (address),
as my patient advocate to make care, custody, or medical treatment decisions for me only when I become unable to participate in medical treatment decisions. The determination of when I am unable to participate in medical treatment decisions shall be made by my attending physician and another physician or licensed psychologist.

OPTIONAL - DESIGNATION OF ALTERNATE PATIENT ADVOCATE: If I revoke my Patient Advocate'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 alternate Patient Advocate:
_____ (name of individual you choose as alternate Patient Advocate)
_____ (address)

I authorize my patient advocate to decide to withhold or withdraw medical treatment which could or would allow me to die. I am fully aware that such a decision could or would lead to my death. In making decisions for me, my patient advocate shall be guided by my wishes, whether expressed orally, in a living will, or in this designation. If my wishes as to a particular situation have not been expressed, my patient advocate shall be guided by his or her best judgment of my probable decision, given the benefits, burdens, and consequences of the decision, even if my death, or the chance of my death, is one consequence.

My patient advocate shall have the same authority to make care, custody, and medical treatment decisions as I would if I had the capacity to make them EXCEPT **(here list the limitations, if any, you wish to place on your patient advocate's authority):**

This designation of patient advocate shall not be affected by my disability or incapacity. This designation of patient advocate is governed by Michigan law, although I request that it be honored in any state in which I may be found. I reserve the power to revoke this designation at any time by communicating my intent to revoke it in any manner in which I am able to communicate. Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document. I voluntarily sign this designation of patient advocate after careful consideration. I accept its meaning and I accept its consequences.

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 and Directive to Physicians)
[ ] Selection of Health Care Agent (Designation of Patient Advocate 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

On the date noted below next to our signatures, in the presence of all of us, the above-named Declarant published and signed this Living Will and Directive to Physicians, and then at the Declarant's request, and in the Declarant's presence, and in each other's presence, we all signed below as witnesses, and we each declare, under penalty of perjury, that, to the best of our knowledge:

(1) The Declarant is personally known to me and, to the best of my knowledge, the Declarant signed this instrument freely, under no constraint or undue influence, and is of sound mind and memory and legal age, and fully aware of the possible consequences of this action.

(2) I am at least nineteen (19) years of age and I am not related to the Declarant in any manner by blood, marriage, or adoption.

(3) I am not the Declarant's attending physician, or a patient or employee of the Declarant's attending physician, or a patient, physician, or employee of the health care facility in which the Declarant is a patient, unless such person is required or allowed to witness the execution of this document by the laws of the state in which this document is executed.

(4) I am not entitled to any portion of the Declarant's estate on the Declarant's death under the laws of intestate succession of any state or country, nor under the Last Will and Testament of the Declarant or any Codicil to such Last Will and Testament.

(5) I have no claim against any portion of the Declarant's estate on the Declarant's death.

(6) I am not directly financially responsible for the Declarant's medical care.

(7) I did not sign the Declarant's signature for the Declarant or on the direction of the Declarant, nor have I been paid any fee for acting as a witness to the execution of this document.

Witness Signature _____ Date _____

Printed Name of Witness _____

Second Witness Signature _____ Date _____

Printed Name of Second Witness _____

Acceptance of Health Care Agent and Patient Advocate

I accept my appointment as Health Care Agent and Patient Advocate:

Signature _____ Date _____

I accept my appointment as Alternate Health Care Agent and Patient Advocate:

Signature _____ Date _____