New York 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 (Order Not to Resucitate)
[ ] Selection of Health Care Agent (Health Care Proxy)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will (Order Not to Resucitate)

I, being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below. I direct my attending physician to withhold or withdraw treatment that merely prolongs my dying, if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, including but not limited to:

(1) a terminal condition,
(2) a permanently-unconscious condition, **OR**
(3) a minimally-conscious condition in which I am permanently unable to make decisions or express my wishes.

I direct that my treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment. While I understand that I am not legally required to be specific about future treatments if I am in the condition(s) described above, I feel especially strongly about the following forms of treatment **(initial those that you choose)**:

[ ] I do NOT want cardiac resuscitation.
[ ] I do NOT want mechanical respiration.
[ ] I do NOT want artificial nutrition and hydration.
[ ] I do NOT want antibiotics.
[ ] However, I DO want maximum pain relief, even if it may hasten my death.

Other directions **(Add instructions and additional pages as needed)**:

These directions express my legal right to refuse treatment, under the law of New York. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

Selection of Health Care Agent (Health Care Proxy)

I, hereby appoint _____(name), of _____ (address), as my health care agent to make any and all health care decisions for me, except to the extent I state otherwise. This health care proxy shall take effect in the event I become unable to make my own health care decisions.

OPTIONAL - DESIGNATION OF ALTERNATE AGENT: 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 alternate agent

_____ (name of individual you choose as alternate agent)
_____ (address)

(NOTE: Although not necessary, and neither encouraged nor discouraged, you may wish to state instructions or wishes, and limit your agent's authority. Unless your agent knows your wishes about artificial nutrition and hydration, he or she will not have the authority to decide about artificial nutrition and hydration. If you choose to state instructions, wishes, or limits, please do so below. Attach additional pages if needed):

I direct my agent to make health care decisions in accordance with my wishes and instructions as stated above or as otherwise known to him or her. I also direct my agent to abide by any limitations on his or her authority as stated above or as otherwise known to him or her. I understand that, unless I revoke it, this proxy will remain in effect indefinitely. **Please initial the box and complete the following only if you DO NOT want your health care proxy to remain in effect indefinitely**:

[ ] This Proxy shall expire on _____

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 (Order Not to Resucitate)
[ ] Selection of Health Care Agent (Health Care Proxy)
[ ] 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 Proxy)

I accept my appointment as Health Care Agent and Health Care Proxy:

Signature _____ Date _____

I accept my appointment as Alternate Health Care Agent and Health Care Proxy

Signature _____ Date _____