Tennessee 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
[ ] Selection of Health Care Agent (Durable Power of Attorney for Health Care)
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will

I, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:
If at any time I should have a terminal condition and my attending physician has determined there is no reasonable medical expectation of recovery and which, as a medical probability, will result in my death, regardless of the use or discontinuance of medical treatment implemented for the purpose of sustaining life or the life process, I direct that medical care be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medications or the performance of any medical procedure deemed necessary to provide me with comfortable care or to alleviate pain.

ARTIFICIALLY-PROVIDED NOURISHMENT AND FLUIDS: **By initialing the appropriate box below, I specifically:**

[ ] DO authorize the withholding or withdrawal of artificially-provided food, water, or other nourishment or fluids.

[ ] do NOT authorize the withholding or withdrawal of artificially-provided food, water, or other nourishment or fluids.

In the absence of my ability to give directions regarding my medical care, 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 care and accept the consequences of such refusal. The definitions of terms used herein shall be as set forth in the Tennessee Right to Natural Death Act, Tennessee Code Annotated, § 32-11-103. I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

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

This is an important legal document. Before executing this document, you should know these important facts: This document gives the person you designate as your agent (the attorney-in-fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document. Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection and health care necessary to keep you alive may not be stopped or withheld if you object at the time. This document gives your agent authority to consent, refuse to consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent: (1) authorizes anything that is illegal, OR (2) acts contrary to your desires as stated in this document. You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital, or other health care provider orally or in writing of the revocation. Your agent has the right to examine your medical records and consent to their disclosure unless you limit this right in this document. Unless you otherwise specify in this document, this document gives your agent the power after you die to: (1) authorize an autopsy, (2) donate your body or parts thereof for transplant, therapeutic, educational, or scientific purposes, and (3) direct the disposition of your remains. If there is anything in this document that you do not understand, you should ask an attorney to explain it to you.

I state and affirm that I have read the foregoing paragraphs concerning the legal consequences of my executing this document, and I do hereby appoint:

_____ (name),
of _____(address),
as my attorney-in-fact to have the authority to express and carry out my specific and general instructions and desires with respect to medical treatment.

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 first alternate agent

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

I have discussed my wishes with my attorney-in-fact, and authorize him or her to make all and any health care decisions (as defined by Tennessee law) for me, including decisions to withhold or withdraw any form of life support. I expressly authorize my agent to make decisions for me about tube feeding and medication.

This power of attorney becomes effective when I can no longer make my own medical decisions and shall not be affected by my subsequent disability or incompetence. The determination of whether I can make my own medical decisions is to be made by my attorney-in-fact.

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
[ ] Selection of Health Care Agent (Durable 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, acknowledged and 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 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 _____