## ADVANCE HEALTH CARE DIRECTIVE OF

(Print Full Name)

#### PART 1: POWER OF ATTORNEY FOR HEALTH CARE

(1) **DESIGNATION OF AGENT:** I designate the following individual as my Agent to make health care decisions for me:

(Print Full Name of Agent)

Address: \_\_\_\_

(Street address of Agent)

(City, State, Zip code of Agent)

Phone:

(Telephone number of 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:

(Print Full Name of Alternate Agent)

Address: \_

(Street address of Alternate Agent)

(City, State, Zip code of Alternate Agent)

Phone:

(Telephone number of Alternate Agent)

- (2) AGENT'S AUTHORITY: My Agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive.
- (3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My Agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [], my Agent's authority to make health care decisions for me takes effect immediately.
- (4) AGENT'S OBLIGATION: My Agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my Agent. To the extent my wishes are unknown; my Agent shall make health care decisions for me in accordance with what my Agent determines to be in my best interest. In determining my best interest, my Agent shall consider my personal values to the extent known to my Agent.

#### PART 2: INSTRUCTIONS FOR HEALTH CARE

(5) END-OF-LIFE DECISIONS: Please choose <u>one</u> of the following regarding end-of-life decisions by initialing your choice:

I choose <u>NOT</u> to prolong life. I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time; (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness; or (3) the likely risks and burdens of treatment would substantially outweigh the expected benefits.

**I choose to prolong life.** I want my life to be prolonged as long as possible within the limits of generally accepted healthcare standards.

# <u>I choose to give my Agent discretion to make end-of-life decisions based on the circumstances.</u>

- (6) **ARTIFICIAL NUTRITION AND HYDRATION:** Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in Paragraph (6).
- (7) **RELIEF FROM PAIN:** *If I mark this box [ ],* I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.
- (8) **DURABILITY:** This Advance Health Care Directive shall not be affected by the subsequent disability or incapacity of the principal, or lapse of time.
- (9) **EFFECT OF COPY:** A copy of this form has the same effect as the original.
- (10) PLANS UPON DEATH: If any, leave blank if no current plans.
- (11) **SIGNATURE:** Sign and date the form here:

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ADDRESS		
CITY	STATE ZIP	
SICN.		
SIGN		
PRINT		

(12) **TWO WITNESSES:** Sign and Date here. *Witnesses cannot be related, must be uninterested parties, cannot be the agent or alternate agent and cannot work in the medical profession.* 

Name	Date	Name	Date
Signature		Signature	
Address		Address	
City, State Zip		City, State Zip	

### STATE OF MISSISSIPPI

COUNTY OF \_\_\_\_\_

On this the \_\_\_\_\_ day of \_\_\_\_\_\_, in the year \_\_\_\_\_, before the undersigned duly appointed Notary Public in and for the jurisdiction aforesaid, the within named, \_\_\_\_\_\_\_, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument in front of myself and two other witnesses, and acknowledged that she/he executed it. I declare under the penalty of perjury that the person whose name is subscribed to in this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

NOTARY PUBLIC

My Commission Expires: