# ADVANCE MEDICAL DIRECTIVE

I, [print name]_____, being of sound mind, an adult of at least 18 years of age or older, and a resident of

[Insert city and state]_____, Willfully and voluntarily make known my wishes in the event that I am incapable of making an informed decision, as follows.

1. I understand that my Advance Medical Directive may include the selection of an agent or proxy decision maker in addition to setting forth my choices regarding health care.
2. The determination that I am incapable of making an informed decision shall be made by my attending physician and a second physician or licensed clinical psychologist after a personal examination of me and shall be certified in writing. The second physician or licensed clinical psychologist shall not be currently involved in my treatment, unless a second physician or licensed clinical psychologist uninvolved in my treatment is not reasonably available. Such certification shall be required before health care is provided, continued, withheld or withdrawn; before any named agent shall be granted authority to make health care decisions on my behalf; and before, or as soon as reasonably practicable after, health care is provided, continued, withheld or withdrawn and every 180 days thereafter while the need for health care continues.
3. If at any time I am determined to be incapable of making an informed decision, I shall be notified, to the extent I am capable of receiving such notice, that such a determination has been made before health care is provided, continued, withheld or withdrawn. Such notice also shall be provided, as soon as practicable, to my named agent or person authorized by this directive to make health care decisions on my behalf. If I am later determined to be capable of making an informed decision by a physician, in writing, upon personal examination, then any further health care decisions will require my personal informed consent.
4. This Advance Medical Directive shall not terminate in the event of my disability.
5. This Advance Medical Directive respects my wishes, and I ask the medical and legal authorities in every state and country to respect them.
6. Any prior appointment of a health care agent, health care representative or health care proxy decision maker, by whatever title so designated, including an appointment that may be made in a document called a “living will” or “durable power of attorney for health care” or “health care proxy” or “health care representative,” is revoked.

## Section I: APPOINTMENT OF HEALTH CARE AGENT

### A. Appointment of My Health Care Agent/Proxy/Representative

I appoint the following person as my **Primary Health Care Agent**, proxy decision maker, and representative (hereafter Health Care Agent) to make any health care decisions for me as authorized in this Advance Medical Directive consistent with the instructions below:

**Name of Primary Health Care Agent** (printed): _____

Address (printed): _____

Telephone number with area code: _____

If the Primary Health Care Agent I appoint above is not reasonably available or is unable or unwilling to act as my agent, then I appoint, as my **First Successor Health Care Agent** the following person:

**Name of 1st Successor Health Care Agent** (printed): _____

Address (printed): _____

Telephone number with area code: _____

If neither the Primary Health Care Agent nor the First Successor Health Care Agent I appoint above is reasonably available, or if neither is willing to act as my health care agent, then I appoint, as my **Second Successor Agent** the following person:

**Name of 2nd Successor Health Care Agent** (printed): _____

Address (printed): _____

Telephone number with area code: _____

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### B. Powers Granted to My Health Care Agent

I hereby grant to my Health Care Agent full power and authority to make health care decisions on my behalf as described below whenever I have been determined to be incapable of making an informed decision about providing, withholding or withdrawing medical treatment.

The powers of my Health Care Agent shall include the following:

1. To visit me in any institution to which I have been transported for emergency care or admitted for inpatient or outpatient health care, and to authorize visitation subject to physician orders and policies of the institution to which I have been transported or admitted.
2. To consent to, refuse, or withdraw any type of health care, treatment, surgical procedure, diagnostic procedure, medication and the use of mechanical or other procedures that affect any bodily function consistent with my instructions below.
3. To request, receive and review any information, verbal or written, regarding my physical or mental health, including but not limited to, medical and hospital records, and to consent to the disclosure of this information.
4. To employ and discharge my health care providers.
5. To authorize my admission to or discharge (including transfer to another facility) from any hospital, hospice, nursing home, other health care facility, or mental health facility.
6. To authorize my admission to a health care facility for the treatment of mental illness for no more than 10 calendar days provided that I do not protest the admission and provided that a physician on the staff of or designated by the proposed admitting facility personally examines me and states in writing that I have a mental illness, that I am incapable of making an informed decision about my admission, and that I need treatment in the facility; and to authorize my discharge (including transfer to another facility) from the facility.
7. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to health care providers, or initiation, prosecution, or defense any legal action related to this Advance Medical Directive.
8. To authorize my participation in any health care study approved by an institutional review board or research review committee pursuant to applicable federal or state law if the study offers the prospect of direct therapeutic benefit to me, or if the study aims to increase scientific understanding of any condition, even though it offers no prospect of direct benefit to me so long as it is consistent with my instructions below.

**C. Duration and Scope of Agent's Authority**

1. My Health Care Agent's authority hereunder is effective as long as I am incapable of making an informed decision.
2. In exercising the power to make health care decisions on my behalf, my Health Care Agent shall follow my desires and preferences as stated in this document or in matters not addressed by my instructions in this document, as otherwise known to my Health Care Agent. My Health Care Agent shall be guided by my medical diagnosis and prognosis and any information provided

by my physicians as to the intrusiveness, pain, risks, side effects, benefits and alternatives associated with treatment or non-treatment. My Health Care Agent shall not authorize a course of treatment which he or she knows, or upon reasonable inquiry ought to know, is contrary to my religious beliefs or my basic values, whether expressed orally or in writing.

3. My Agent shall not be liable for the costs of treatment pursuant to my Agent's authorization, based solely on that authorization.

## SECTION II: INSTRUCTIONS ABOUT MY HEALTH CARE TO MY HEALTH CARE AGENT AND ALL MEDICAL PERSONNEL

### A. General Instructions: A Presumption for Life

1. My desires and preferences are grounded in the Judeo-Christian moral tradition, which views human life as a gift of a loving God. This tradition further respects the life of each and every human being because each human being is made in the image and likeness of God and therefore has a special value and significance. I believe that Jesus has conquered sin so that death has lost its sting (*1 Cor. 15:55*), that death need not be resisted by any and every means, and that by death "life is changed, not ended." (*Preface I For the Dead*).
2. As a member of the Catholic Church, I wish to follow the moral teachings of the Church, or though not a member of the Catholic Church, I nonetheless direct my Health Care Agent to adhere to the moral teachings of the Catholic Church when making health care decisions on my behalf. I wish to receive all the obligatory care and treatment that the Catholic Church teaches we have a duty to accept. Such care and treatment is ordinary or proportionate care because it offers a reasonable hope of benefit to me without imposition of excessive burden such as serious risk of death or serious injury, excessive pain, or excessive expense to me or my family. I also have the moral and legal right to refuse extraordinary or disproportionate medical treatment that has no reasonable hope of benefit to me, is excessively burdensome to me, or imposes excessive expensive on me or my family. I also know that I may morally receive proportionate medication to relieve pain even if it is foreseen that its use may have the unintended result of shortening my life. I direct that those caring for me avoid doing anything that is contrary to the moral teachings of the Catholic Church. Those making decisions on my behalf shall be guided by the moral teachings of the Catholic Church, including the teachings contained in the following documents: *Declaration on Euthanasia* by the Sacred Congregation for the Doctrine of the Faith (1980); *The Ethical and Religious Directives Ethical and Religious Directives for Catholic Health Care Services,* adopted by the United States Conference of Catholic Bishops (2018), and the Address of John Paul II to the *Participants in the international*

*Congress on Life Sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas* (2004).

3. If those caring for me or directing my care are unsure of the content of the relevant teachings of the Catholic Church or how they apply to my health care in a particular circumstances, I request that they review them as soon as possible and that a certified Catholic chaplain or a Catholic cleric (bishop, priest or deacon) be consulted to provide further guidance. In such an event, the chaplain or cleric shall be provided with a copy of this directive and shall affirm that he or she has read it in its entirety before those caring for me or directing my care may rely on his or her advice or input.
4. In principle, there is an obligation to provide patients with nutrition and hydration, including medically assisted nutrition and hydration for those who cannot take food or water orally. Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be excessively burdensome or would cause significant physical discomfort. In that circumstance my Health Care Agent and those caring for me shall be guided by the principles set forth above. I direct my Health Care Agent to authorize, and my health care providers to provide, nutrition and hydration orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible, unless or until the benefits of such nutrition and hydration are clearly outweighed by a definite danger or burden, or are useless in achieving their intended outcome.
5. I reject in any situation any treatment that directly uses an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who is a product of an induced abortion.
6. I reject in any situation any treatments that use an organ or tissue of another person obtained in a manner that directly causes, contributes to, or hastens that person's death.
7. It is my intention that the instructions in this document are to be followed even if it is alleged that I have attempted suicide at some point after it is signed.
8. I direct that my life not be ended by assisted suicide or euthanasia, the latter meaning an action or omission that would directly and intentionally cause my death.

**B. Particular Instructions Concerning Life-Prolonging Treatment**

When I am in the final stages of a terminal illness or injury or when my death is imminent and unavoidable, I instruct that I be informed of this so that I may prepare myself for death. Furthermore, I request (initial each item you request):

- ____ That I be attended by a Catholic priest and be provided the opportunity to receive the Sacraments of the Church (Reconciliation, Holy Eucharist and the Anointing of the Sick) if I am Catholic.

- ____ To the degree possible, that all reasonable steps are taken to allow me to see my family and to reconcile with anyone from whom I may have become estranged.
- ____ To the degree possible, that I be permitted to die at home or in a hospice that has the appearance of a home setting.

After reasonable efforts have been made to satisfy my requests as confirmed above, I direct the following when I am in the final stages of terminal illness or injury or when my death in imminent and unavoidable (initial only ONE choice):

- ____ That the application of all life-prolonging procedures (including assisted ventilation, cardiopulmonary resuscitation, and invasive procedures) be withdrawn or withheld, and that I be permitted to die naturally with only the administration of medications and the performance of medical procedures deemed necessary to ensure my comfort and alleviate pain.

**OR**

- ____ That all treatments to prolong my life as long as reasonably possible be continued.

**OR**

- ____ That I choose to provide no written guidelines and direct my Health Care Agent to make end-of-life decisions based on my known values and wishes.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this Advance Medical Directive shall be honored by my family and physician as the final expression of my legal right to direct my health care and my acceptance of the consequences of such direction. In all cases, I direct that decisions about my medical treatment and health care be made in accordance with Catholic moral teachings.

**C. Additional Health Care Instructions for Women**

If I am pregnant, I direct that, regardless of my physical or mental condition, all medically available procedures, including medically assisted nutrition and hydration, be provided to sustain my life and the life of my unborn child until birth or at least until the child's viability is attained followed by delivery by caesarian section or otherwise. No one is authorized to consent to any treatment or procedure for me whose sole immediate and directly intended effect is the termination of my pregnancy before the viability of my unborn child is attained.

I understand that I may morally accept or refuse operations, medications and forms of treatment that have as their direct purpose the cure of a serious pathological condition when these interventions cannot be safely postponed until the viability of my unborn child is attained, even if such interventions may indirectly result in the death of my unborn child. If I am determined to be incapable of providing consent for such interventions, I (initial ONE choice):

____ Grant the authority to my Health Care Agent to consent to or refuse such interventions.

____ Do not grant the authority to my Health Care Agent to consent to or refuse such interventions.

**SECTION III:**

**APPOINTMENT OF AN AGENT TO MAKE AN ANATOMICAL GIFT OR ORGAN, TISSUE OR EYE DONATION (This Section is Optional)**

*(CROSS THROUGH THIS SECTION IF YOU DO NOT WANT TO APPOINT AN AGENT TO MAKE AN ANATOMICAL GIFT OR ANY ORGAN, TISSUE OR EYES FOR YOU)*

1. Legal Authorization. Upon my certain death, as described in item 2 of this section below, I direct that an anatomical gift of all of my body or certain organ, tissue or eyes may be made by my Health Care Agent, in accordance with applicable law and in accordance with my directions below.
2. My certain death shall be determined by one of the following means: 1) the irreversible cessation of all respiratory and circulatory function, or 2) by the cessation of all brain function, including the brain stem, which shall be confirmed by electroencephalography (EEG). If an EEG forms the basis of the determination of certain death, it shall be interpreted by a neurologist who must confirm that it reveals the total absence of brain function before it may be relied on by my agent or any one else for the purpose of making any anatomical gift.
3. No ovum or sperm shall be extracted from an anatomical gift or organ or tissue donation obtained from my corporeal remains for the purpose of creating an embryo.

**SECTION IV:**

**AFFIRMATION AND RIGHT TO REVOKE**

By signing below, I state that I am emotionally and mentally capable of making this Advance Medical Directive and that I understand the purpose and effect of

this document. I understand that I may revoke all or any part of this document at any time (i) with a signed, dated writing; (ii) by physical cancellation or destruction of this Advance Medical Directive by myself or by directing someone else to destroy it in my presence; or (iii) by my oral expression of intent to revoke.

Copies of this document carry the full force and authority as the original. The original of this document is in the possession of or can be found at [print name or specify location where original document can be found]:

_____

_____

_____

**SIGNATURE AND WITNESSES:**

X_____
Signature of Declarant and Date

**The declarant is at least 18 years of age and voluntarily dated and signed the foregoing Advance Medical Directive in my presence, without any appearance of being under duress, undue influence or fraud.**

First Witness name and address: _____

First Witness signature and date: X_____

Second Witness name and address: _____

Second Witness signature and date: X_____