

ADVANCE HEALTH CARE DIRECTIVE INSTRUCTIONS

Use **BLUE INK ONLY** when filling this form out

PAGE 1

Advance Health Care Directive of

My _____ Date of Birth _____

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Michigan. No matter what form you use, talk to your family and other doctors to discuss your wishes during possible medical events.

If the form reflects what your health care decisions are even if you cannot, you do not want to make your own health care decisions. The person you pick to be your health care agent. Ask your family to your health care agent. List any back-up agents about this important role.

This form documents your preferences about efforts to extend your life in three situations: terminal condition, permanent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out a second form.

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

I am of legal age and of sound mind, execute this advance health care directive freely and voluntarily, with an understanding of its purpose and consequences. I intend to create this medical durable power of attorney under the laws of the State of Michigan. I further intend to demonstrate my wishes concerning medical treatment with clear and convincing evidence. It seems reasonable to believe that the powers and decisions granted by me or predicted except powers granted by me under any state statutory Advance Health Care Directive.

Article One
Recitals

Section 1.01 Designation of Health Care Agent

I designate the individual named below to serve as my Health Care Agent. If you, the Health Care Agent, are unable to make decisions with respect to my health care if I am unable to make my own health care decisions.

Name _____
 Address _____
 Phone _____

Advance Health Care Directive
 Page 1 of 2
 Print Initial _____

Write your date of birth here.

Write your full legal name here, the same as it appears on your driver's license.

Enter the name, address and phone number of someone you trust to make medical decisions on your behalf. This person needs to be over the age of 18 and preferably someone that can be easily reached.

Initial the bottom of the page.

PAGE 2

_____ is unable to serve. I designate the individual in the order listed below as my Health Care Agent to exercise the powers and decisions set forth in this instrument.

Name _____
 Address _____
 Phone _____

Section 1.02 Designation of Primary Physician

I designate the physician named below as my primary physician.

Name _____
 Address _____
 Phone _____

Section 1.03 Duration

This Advance Health Care Directive expires at the earliest of:

- my divorce or the annulment of my marriage;
- my death (except for post-death matters allowed under Michigan law); or
- my revocation of this Advance Health Care Directive.

However, the medical information and medical records provisions described in Section 2.03 continue in effect for an additional 24 months from the date of my death, unless revoked. My Health Care Agent's authority does not terminate if I become disabled or incapacitated.

Section 1.04 General Grant

My Health Care Agent may determine and implement all actions necessary for my personal care, residential placement, and medical treatment, including the items specifically mentioned in this instrument. If my Health Care Agent is not available, I intend to guide doctors about my care and treatment with the following statements:

Section 1.05 Pregnancy

My Agent may make health care decisions for me even if my Agent knows that I am pregnant.

Advance Health Care Directive
 Page 2 of 2
 Print Initial _____

Write the name of your agent from page 1.

Write the name of an **alternative agent** to make medical decisions on your behalf here. Same rules apply.

Write the name and information for your Primary Physician here.

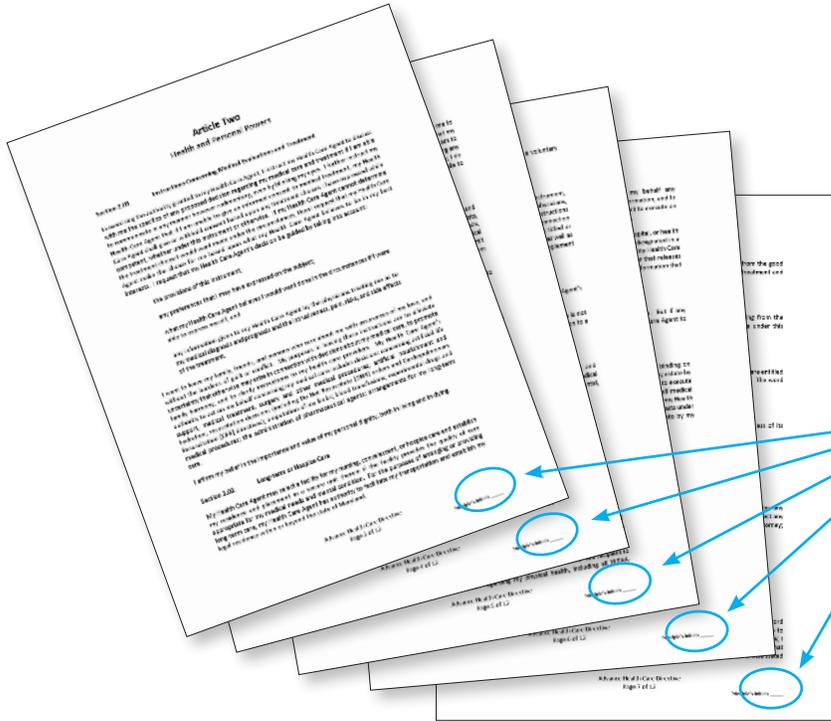
Note: this is the same person you should give a copy of this completed document to.

Initial the bottom of the page.



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PAGES 3-7



Initial the bottom of the pages.

PAGE 8

In this section you may write specific personal preferences, this is optional. For example; I would prefer a single room; I want family to visit regardless of the situation; religious preferences.

Write which of the two options you choose for when your agent's power is in effect and then initial the second line.

Read through the "Living Will" on pages 8-10. In sections A-E initial **YOUR CHOICE** in each section (only have one selection per section).

Initial the bottom of the page.

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PAGES 8-10

Read through the "Living Will" on pages 8-10. In sections A-E initial **YOUR CHOICE** in each section (only have one selection per section).

In _____ this document.

I ask that my agent respect my wishes as noted under the section titled "Treatment Preferences, but and the following conditions or limitations (Optional, from which I wish to be bound):

Effectiveness of this power

This agent's power is in effect:

- immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to;
- whenever I am not able to make informed decisions about my health care, either because a doctor in charge of my care decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability permanently;

I choose option: _____ Initial: _____

TREATMENT PREFERENCES ("LIVING WILL")

A. Preferences in Case of Terminal Condition

If my doctors certify that my death from a terminal condition is imminent, even if life sustaining procedures are used:

- Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means. >>> **OR** <<<
- Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means. >>> **OR** <<<

Advance Health Care Directive Page 8 of 12 Initial: _____

As long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

In Case of Persistent Vegetative State

I certify that I am in a persistent vegetative state, that is, if I am not conscious and am incapable of my environment or able to interact with others, and there is no reasonable hope that I will ever regain consciousness:

- Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means. >>> **OR** <<<
- Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means. >>> **OR** <<<

Advance Health Care Directive Page 9 of 12 Initial: _____

As long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

C. Preferences in Case of End Stage Condition

If my doctors certify that I am in an end-stage condition, that is, an incurable condition that will ultimately lead to my death and that has already resulted in loss of capacity and complete physical dependency:

- Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means. >>> **OR** <<<
- Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means. >>> **OR** <<<

Advance Health Care Directive Page 10 of 12 Initial: _____

I wish to consent to receive anything that might happen after I can no longer decide for myself. This consent covers all medical decisions on my behalf and my health care provider to follow my statements herein exactly as written, even if they think that some alternative is better.

Signature: _____ Date: _____

Advance Health Care Directive Page 11 of 12 Initial: _____

Sign and date here **ONLY IN THE PRESENCE OF A NOTARY PUBLIC!**

Initial the bottom of the pages.

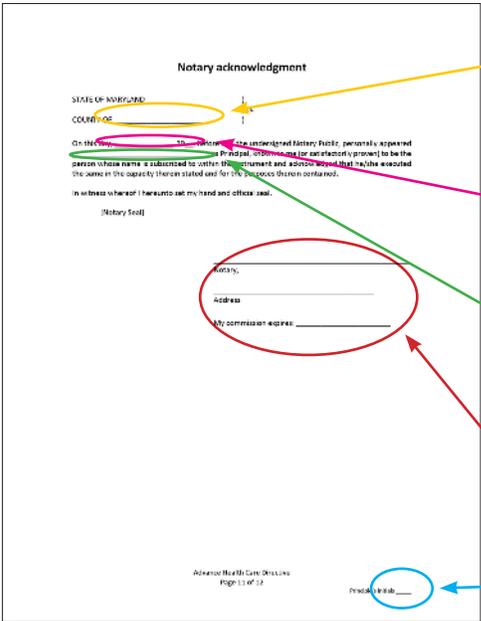
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PAGE 11

**THIS PAGE SHOULD ONLY BE COMPLETED
IN THE PRESENCE OF A NOTARY PUBLIC!**

You can most commonly find a Notary Public at your bank or a law firm, such as ours.

**You must have two witnesses over the age of 18 present at signing.
It is preferred that your witnesses NOT be one of the agents
that you identified on pages 1 and 2.**



The image shows a 'Notary acknowledgment' form with several colored annotations:

- A yellow oval highlights the 'COUNTY' field.
- A pink oval highlights the date field (Day, month, and year).
- A green oval highlights the 'Notary Public' name and address fields.
- A red oval highlights the 'Notary Public' signature line.
- A blue circle highlights the 'Initials' field at the bottom right.

County where this document is being notarized. E.g. Anne Arundel.

Day, month, and last 2 digits of the year that this is being signed.

Write your full legal name in here.

This information is filled out by a Notary Public.

Initial the bottom of the page. This can be done ahead of time.

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PAGE 12

If you DO NOT want anything in this section then draw a diagonal line through the page and sign on that line.

The image shows a sample of the 'After My Death' form. Key areas are highlighted with colored circles and arrows:

- Yellow circle:** Points to the 'Full legal name' field.
- Pink circle:** Points to the 'Date of Birth' field.
- Green circle:** Points to the 'Any needed organs, tissues, or eyes' section.
- Yellow circle:** Points to the 'Authorize the use of my organs, tissues, or eyes' section.
- Blue circle:** Points to the signature line at the bottom of the page.

Write your full legal name here, the same as it appears on your driver's license.

Write your date of birth here.

If you wish to donate all organs, initial the top line. To donate particular organs specify in the area provided and initial bottom line.
 If you do not wish to donate any organs draw a diagonal line through to indicate NO.

Authorize how your organs may be used by initialing lines for YES; draw a diagonal line through to indicate NO.

Initial the bottom of the page.

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PAGE 13

Part Two: Donation of Body
After any organ donation indicated in Part 1, I authorize my body to be donated for use in a medical study program.

Part Three: Disposition of Body and Funeral Arrangements
I want the following person to make decisions about the disposition of my body and my funeral arrangements:
1. The health care agent who I named above in my advance directives.
OR
2. This person:
Name: _____
Address: _____
Telephone: _____
If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other people's funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

Advance Health Care Directive
Page 13 of 14
Initials:

If you wish to donate your body for use in a medical study program initial for YES; draw a diagonal line through to indicate NO.

If you would like the agent you named on page 1 to handle the disposition of your body and funeral arrangements initial option one.

If you would like to name someone else to handle the disposition of your body and funeral arrangements write their information and initial option two.

This section is optional. If you have any specific wishes in regards to the disposition of your body or funeral arrangements write them here.

Initial the bottom of the page.

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PAGE 14

THIS PAGE SHOULD ONLY BE COMPLETED IN THE PRESENCE OF A NOTARY PUBLIC!

You can most commonly find a Notary Public at your bank or a law firm, such as ours.

You must have two witnesses over the age of 18 present at signing. It is preferred that your witnesses NOT be one of the agents that you identified on pages 1 and 2.

Write the name of each witnesses here.

Write your name here.

Each witness should fill out their information and sign **in front of the Notary Public**.

County where this is being notarized.

Day, month, and last 2 digits of the year that this is being signed.

Names of each witness.

This is filled out by a Notary Public.

Initial the bottom of the page. This can be done ahead of time.