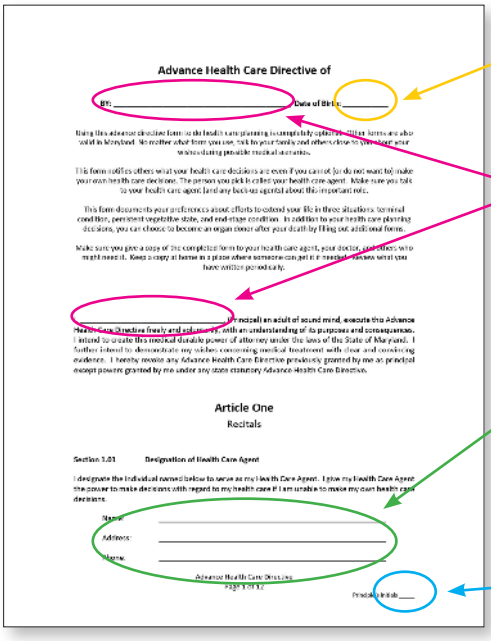
ADVANCE HEALTH CARE DIRECTIVE INSTRUCTIONS

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

PAGE 1



Advance Health Care Directive of

Article One
Recitals

Section 1.01 Designation of Health Care Agent

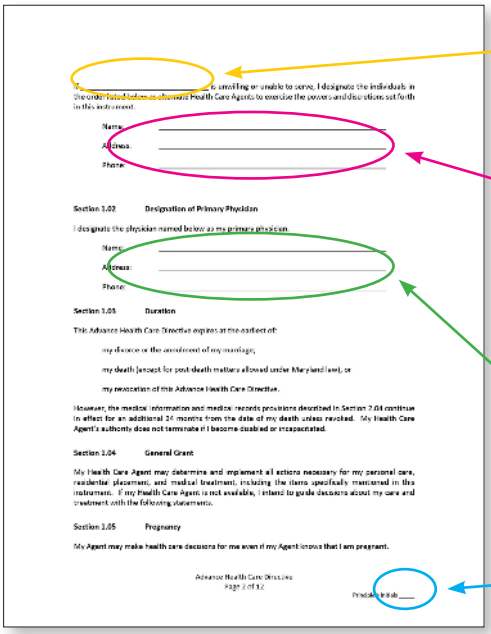
Write your date of birth here.

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



Section 1.02 Designation of Primary Physician

Section 1.03 Duration

Section 1.04 General Grant

Section 1.05 Pregnancy

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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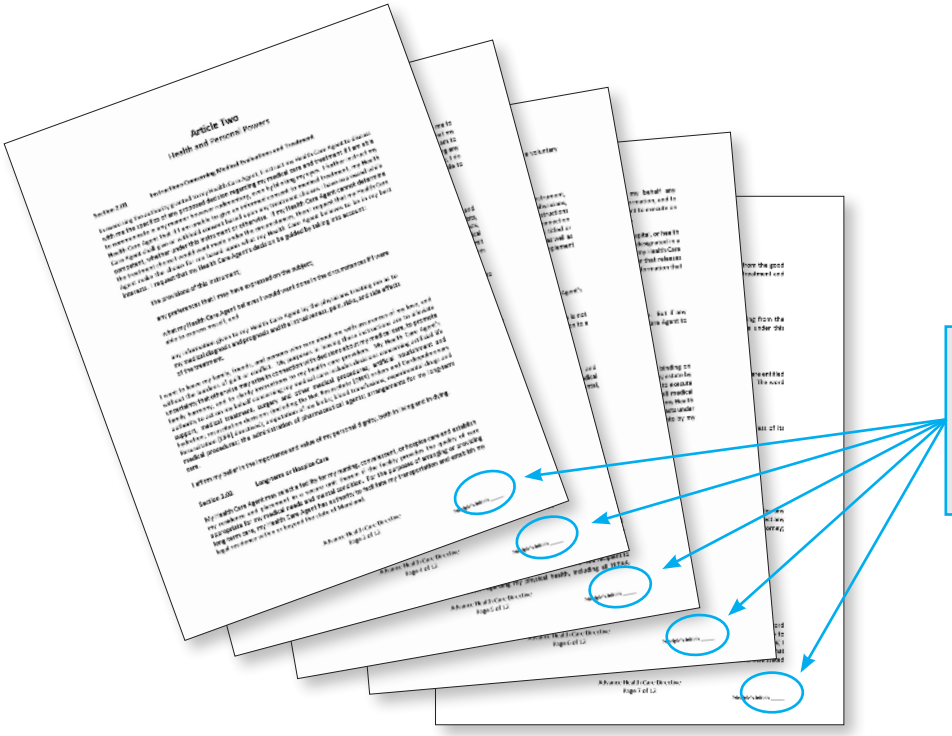
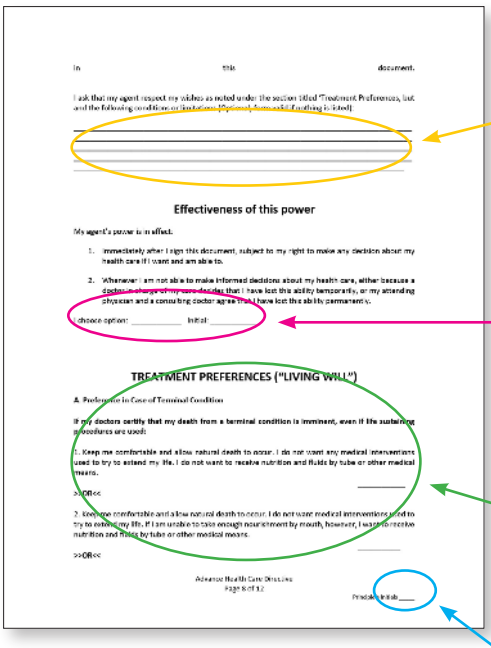
PAGES 3–7



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 inital **YOUR CHOICE** in each section (only have one selection per section).

Initial the bottom of the page.

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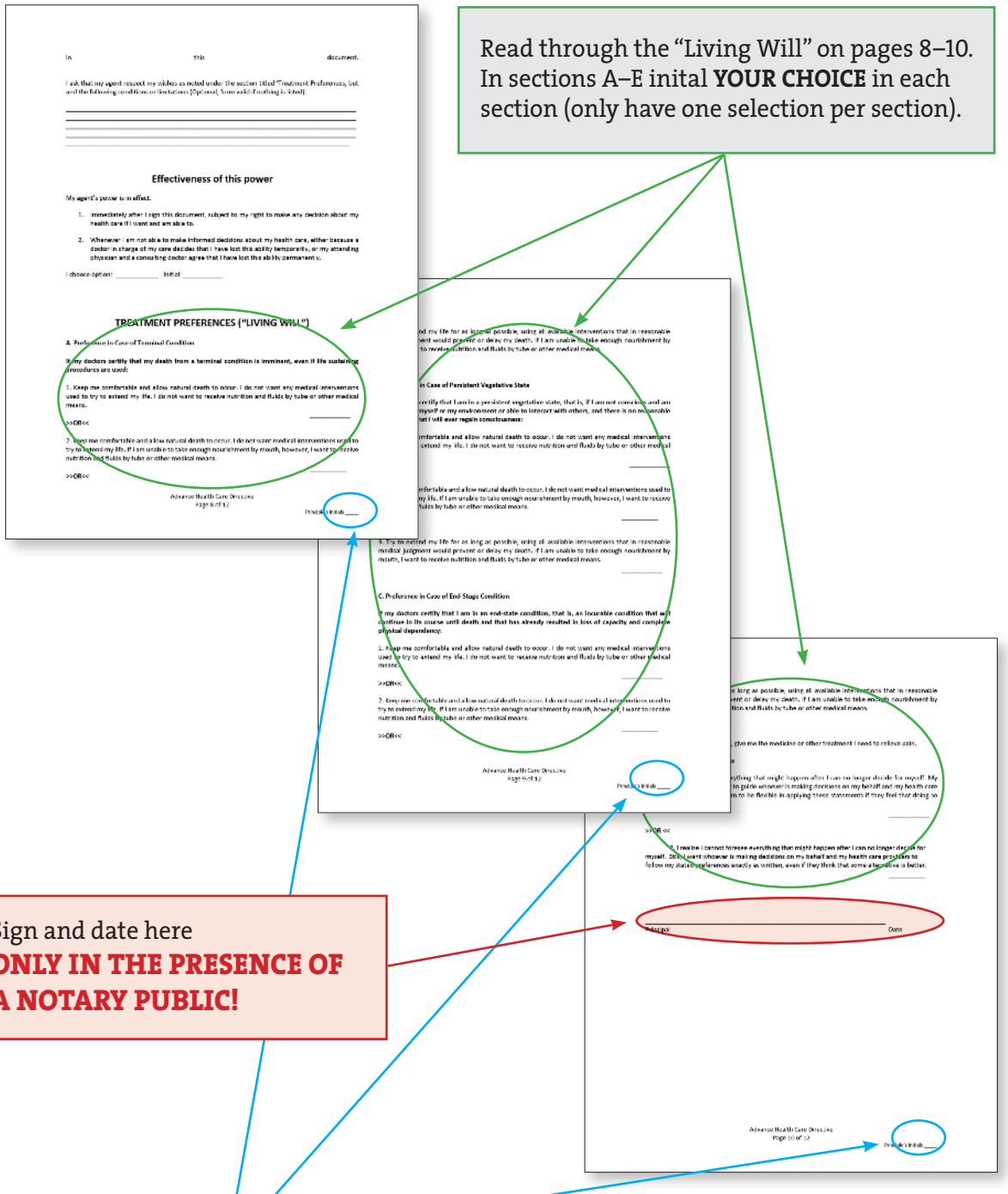
PAGES 8-10



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

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

Initial the bottom of the pages.

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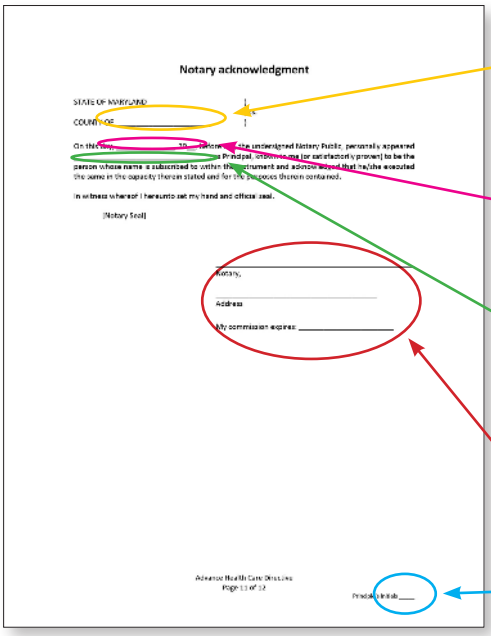
PAGE 11

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 prefered that your witnesses NOT be one of the agents
that you identified on pages 1 and 2.**


Notary acknowledgment

STATE OF MARYLAND

COUNTY OF _____

On the ____ day of _____, 20__, before me, the undersigned Notary Public, personally appeared _____, Principal, proved to me (or satisfactorily proven) to be the person whose name is subscribed to within the instrument and acknowledged that he/she executed the same in the capacity therein stated and for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

[Notary Seal]

Notary: _____

Address: _____

My commission expires: _____

Advance Health Care Directive
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Principal Initials: ____

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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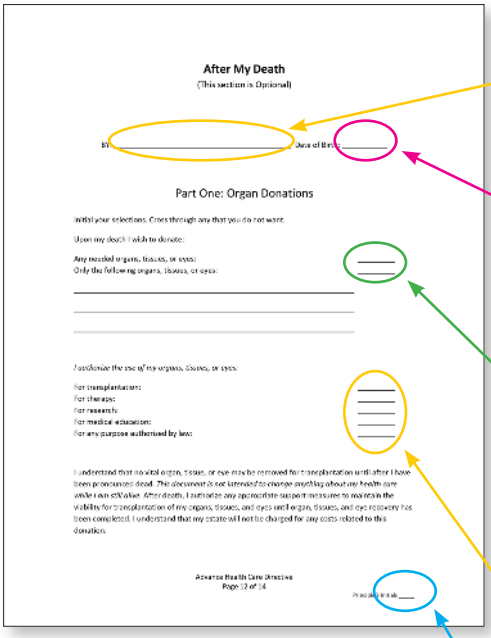
PAGE 12

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



After My Death
(This section is Optional)

I, _____ Date of Birth: _____

Part One: Organ Donations

Initial your selections. Cross through any that you do not want.

Upon my death I wish to donate:

Any needed organs, tissues, or eyes: ____
Only the following organs, tissues, or eyes: ____

_____

_____

_____

I authorize the use of my organs, tissues, or eyes:

For transplantations: ____
For therapy: ____
For research: ____
For medical education: ____
For any purpose authorized by law: ____

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead. This document is not intended to change anything about my health care while I am still alive. After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissues, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

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Initials: ____

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, intial the top line. To donate particular organs specify in the area provided and inital 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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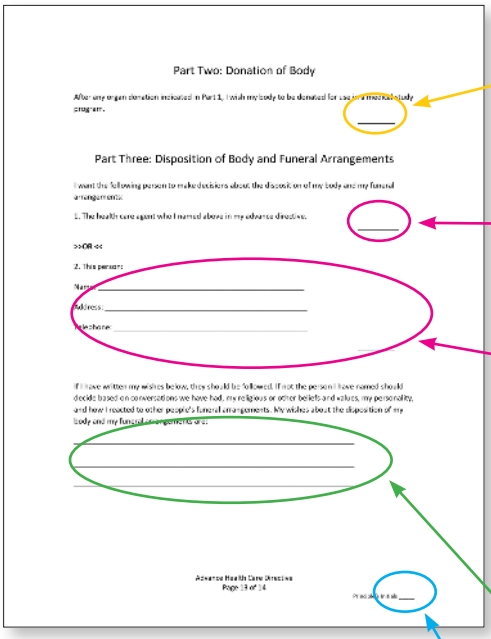
PAGE 13



Part Two: Donation of Body

After any organ donation indicated in Part 1, I wish 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 directive. ____

>>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
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Initials: ___

If you wish to donate your body for use in a medical study progam 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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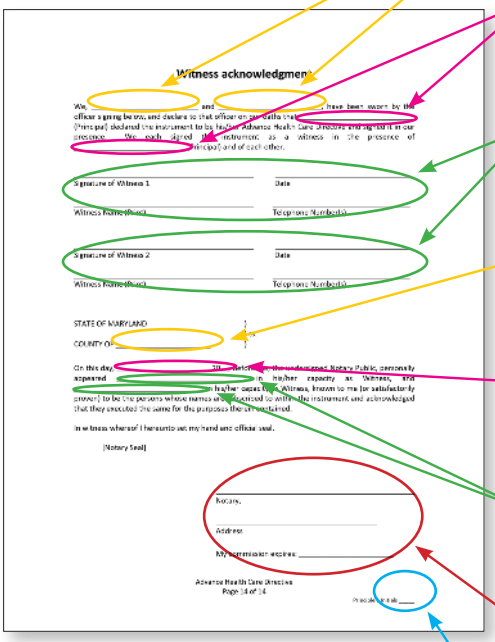
PAGE 14

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 prefered that your witnesses NOT be one of the agents
that you identified on pages 1 and 2.**


Witness acknowledgment

We, _____ and _____, have been sworn by the officer signing below, and declare to that officer on our oaths that the principal declared the instrument to be his/her Advance Health Care Directive and signed it in our presence. We each signed the instrument as a witness in the presence of the principal and of each other.

Signature of Witness 1 _____ Date _____

Witness Name Printed _____ Telephone Number(s) _____

Signature of Witness 2 _____ Date _____

Witness Name Printed _____ Telephone Number(s) _____

STATE OF MARYLAND

COUNTY OF _____

On this day, _____, before me, the undersigned Notary Public, personally appeared _____ in his/her capacity as Witness, and _____ in his/her capacity as Witness, known to me [or satisfactorily proven] to be the persons whose names are subscribed to within the instrument and acknowledged that they executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

[Notary Seal]

Notary _____

Address _____

My commission expires: _____

Advance Health Care Directive
Page 14 of 14

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.