HOLY CROSS HEALTH

ADVANCE DIRECTIVES

As a public service project, the Health Law Section of the Maryland State Bar Association has prepared the attached "Advance Directive." This form gives instructions as to your wishes if you should become too sick to make health care decisions for yourself and as to your wishes as to disposal of your remains. Before filling this form out, you should read "Making Decisions About Your Care."

You may wish to complete only the first part of the attached form, or only the second part, or only selected parts; however, we recommend that you fill out all of both parts of the attached form. You should review, initial and date this form regularly to make sure that it still reflects your wishes, and be sure to fill out a new form if there is a significant change in your wishes, your health condition or your family relationships.

This form complies with Maryland law. However, the law in other states may be different. If you will be treated outside of Maryland, you should check with a health care provider or attorney in that area to see if this form is acceptable.

APPOINTMENT OF A HEALTH CARE AGENT (Part One)

1. I, _____ , appoint the following person as my agent to make health care decisions for me as authorized in this document:

_____ _____
name home address

_____ _____
daytime telephone number evening telephone number

[Optional]: If the person named above is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following person to serve as my agent:

_____ _____
name home address

_____ _____
daytime telephone number evening telephone number

[Optional]: If neither person is reasonably available or neither will act as my agent, then I appoint the following person to serve as my agent:

_____ _____
name home address

_____ _____
daytime telephone number evening telephone number

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2. I grant to my agent named above full power and authority to make health care decisions on my behalf, including those about life-sustaining care, subject to these special instructions:

_____

3. My agent's authority to make decisions begins ***(initial one)***:

_____ When my doctor decides that I am not able to make health care decisions; or

_____ When I tell my doctor that I want my agent to make health care decisions for me; or

_____ When I sign this form.

4. My agent is to make health care decisions for me based on the instructions in this document and on my wishes as known to my agent. If my wishes are unknown or unclear, my agent is to make health care decisions for me based on my best interests after considering the possible good or bad results from treatment or from the withholding or withdrawal of treatment.

5. My agent shall not be responsible for the cost of my care based solely on this document.

HEALTH CARE INSTRUCTIONS (Part Two)

If I am not able to make an informed decision regarding my health care, I direct my agent, doctor, hospital, and other health care providers to follow these instructions:

1. If I am close to death due to illness, injury or disease and my doctors believe there is no reasonable hope of recovery, even with life-sustaining procedures, I direct that my life ***(initial one)***:

_____ Not be extended by any medical treatment except comfort care and medication to alleviate pain.

_____ Not be extended by any life-sustaining procedures (such as tube feeding, ventilators, and CPR).

_____ Not be extended by life-sustaining procedures, except that if I cannot take food or liquids by mouth, I wish to be tube-fed.

_____ Be extended by all available medical means in accordance with accepted health care standards.

2. If I am permanently unconscious and my doctors believe that there is no reasonable hope of recovery, I direct that my life ***(initial one)***:

_____ Not be extended by any medical treatment except comfort care and medication to alleviate pain.

_____ Not be extended by any life-sustaining procedures (such as tube feeding, ventilators, and CPR).

_____ Not be extended by life-sustaining procedures, except that if I cannot take food or liquids by mouth, I wish to be tube-fed.

_____ Be extended by all available medical means in accordance with accepted health care standards.

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3. If I have become so sick or seriously injured from a progressive condition that I am unable to make medical decisions and I am completely dependent on others with no reasonable hope of recovery, I direct that my life ***(initial one)***:

   _____ Not be extended by any medical treatment except comfort care and medication to alleviate pain.

   _____ Not be extended by any life-sustaining procedures (such as tube feeding, ventilators, and CPR).

   _____ Not be extended by life-sustaining procedures, except that if I cannot take food or liquids by mouth, I wish to be tube-fed.

   _____ Be extended by all available medical means in accordance with accepted health care standards.

4. I further direct that (indicate any other instructions regarding the receipt or non-receipt of health care):

   _____.

5. If I am pregnant, my decisions concerning life-sustaining procedures are modified as follows:

   _____.

6. I provide the following instructions regarding donation of my organs and tissues ***(initial one)***:

   _____ I want to donate all of my organs and tissues.

   _____ I do not wish to donate any of my organs and tissues.

   _____ I wish to donate only these organs and tissues:

   _____ .

   _____ Other wishes: _____ .

7. After my death, I ***(initial one)***:

   _____ wish to be cremated.

   _____ do not wish to be cremated.

By signing below, I indicate that I understand the purpose and effect of this document.

_____ _____

Signature Date

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WITNESSES

I declare that the person whose signature appears on this document signed or acknowledged the document in my presence and appears to me to be a competent individual free from duress, fraud, or undue influence. I declare that I am not a person appointed as an agent by this document. At least one of us is not knowingly entitled to any portion of the estate of the declarant or knowingly entitled to any financial benefit by reason of the death of the declarant.

First Witness

Signature: _____

Print Name: _____

Home Address: _____

Date: _____

Second Witness

Signature: _____

Print Name: _____

Home Address: _____

Date: _____

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Living Will
(Optional Form)

If I am not able to make an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below. *(**Initial** those statements you wish to be included in the document and **cross through** those statements which do not apply).*

A. If my death from a terminal condition is imminent and even if life-sustaining procedures are used there is no reasonable expectation of my recovery:

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that, if I am unable to take food and water by mouth, I wish to receive nutrition and hydration artificially.

_____ I direct that, even in a terminal condition, I be given all available medical treatment in accordance with accepted health care standards.

B. If I am in a persistent vegetative state, that is, if I am not conscious and am not aware of my environment nor able to interact with others, and there is no reasonable expectation of my recovery within a medically appropriate period:

_____ I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life not be extended by life-sustaining procedures, except that, if I am unable to take food and water by mouth, I wish to receive nutrition and hydration artificially.

_____ I direct that I be given all available medical treatment in accordance with accepted health care standards.

C. If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

_____

_____

By signing below, I indicate that I am emotionally and mentally competent to make this Living Will and that I understand its purpose and effect.

_____ _____

Date Signature of Declarant

The declarant signed or acknowledged signing this Living Will in my presence and, based upon my personal observation, appears to be a competent individual.

_____ _____

Witness Witness

_____ _____

Signature and Addresses of Two Witnesses

SSSTK1006