

ADVANCED DIRECTIVES OF _____

This document contains the following:

1. my Living Will or Health Care Instructions,
2. my Appointment of a Health Care Agent,
3. my Appointment of an Attorney-in-Fact for Health Care Decisions, and
4. the Designation of the Conservator of my Person regarding my Future Incapacity.

As my physician, you may rely upon any information given to you by my health care agent and decisions made by my attorney-in-fact and my conservator if I am unable to make a given decision for myself.

LIVING WILL OR HEALTH CARE INSTRUCTIONS

If the time comes when I am incapacitated to the extent that I can no longer take part in decisions for my own life, and I am unable to direct my physician as to my own medical care, I wish this statement to stand as a testament of my wishes.

I, _____, the author of these advanced directives, request that, if my condition is judged to be terminal or if I am deemed to be permanently unconscious, I be allowed to die and that I not be kept alive through life support systems. By "terminal condition," I mean that I have an irreversible or an incurable medical condition which, without the administration of life support systems, will, in the judgment of my attending physician, result in death within a relatively short time. By "permanently unconscious," I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time cognizant of myself or my environment and demonstrate no behavioral response to my environment.

Specific Instructions

My instructions regarding particular types of life support systems are listed below. This list is not all-inclusive. My general statement that I not be kept alive through life support systems is limited only where I have indicated that I desire a particular treatment to be provided.

	<u>Provide</u>	<u>Withhold</u>
Cardiopulmonary Resuscitation	_____	_____
Artificial Respiration (including a respirator)	_____	_____
Artificial means of providing nutrition and hydration	_____	_____
_____	_____	_____
_____	_____	_____

Other specific requests: _____

I want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but intend only that my dying not be unreasonably prolonged.

*Please read and complete the Advanced Directives (pages 1-4).

**APPOINTMENT OF HEALTH CARE AGENT AND
ATTORNEY-IN-FACT FOR HEALTH CARE DECISIONS**

I appoint _____ to be my health care agent and my attorney-in-fact for health care decisions. If my attending physician concludes that I am unable to comprehend and appreciate the nature and consequences of health care decisions and that I am unable to formulate and communicate an informed decision regarding treatment, _____ is authorized,

As My Health Care Agent to:

- (1) convey my wishes concerning the withholding or removal of life support systems to my physician; and
- (2) take whatever actions are necessary to ensure that my wishes are implemented.

As My Attorney-In-Fact to:

- (1) act in my name, place, and stead in any way which I myself could do, if I were personally present and under no disability, with respect to health care decisions as defined in the Illinois Statutory Short Form Power of Attorney For Health Care Act to the extent that I am permitted by law to act through an agent; and
- (2) consent, refuse, or withdraw consent to any medical treatment **other than** that designated solely for the purpose of maintaining physical comfort, withdrawal of life support systems, or withdrawal of nutrition or hydration.

If _____ is unwilling or unable to serve as my health care agent and my attorney-in-fact for health care decisions, I appoint _____ to be my alternate health care agent and my attorney-in-fact for health care decisions.

These Advanced Directives may be amended or revoked by me in the manner provided in Section 4-6 of the Illinois Powers of Attorney for Health Care Law. Absent amendment or revocation, the authority granted in these Advanced Directives will become effective at the time the documents are signed and will continue until my death and beyond if anatomical gift, autopsy, or disposition of remains is authorized, unless a limitation on the beginning date and duration is made by completing and initialing either or both of the following.

- 1. () These Advanced Directives become effective on _____
Initial (insert a future date/event such as a court determination of your disability when you want this power to take effect)
- 2. () These Advanced Directives shall terminate on _____
Initial (insert a future date/event such as a court determination of your disability when you want this power to terminate prior to your death)

WITNESSES' AFFIDAVITS

STATE OF ILLINOIS)
 : **SS**
COUNTY OF LOGAN)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointments of a health care agent and an attorney-in-fact, and the designation of a conservator for future incapacity by the author of these Advanced Directives that the author subscribed, published and declared the same to be the author's instructions, appointments, and designation in our presence; that we thereafter subscribed these documents as witnesses at the author's request, in the author's presence, and in the presence of each other; that at the time of the execution of said documents, the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said documents, and under no undue influence to execute said documents; and that we will make this affidavit at the author's request this _____ day of _____, 20__.

(Witness)

(Witness)

Subscribed and sworn to before me this _____ day of _____, 20__.

Logan County Clerk of the Circuit Court
Notary Public
My Commission Expires _____

(Print or type name of each person signing under the respective signature.)