ADVANCE DIRECTIVES OF _____ D.O.B. _____

LIVING WILL or HEALTH CARE INSTRUCTIONS

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

I, _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems.

By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion 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 aware of myself or the environment and show no behavioral response to the environment.

Specific Instructions

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

	Provide	Withhold
Cardiopulmonary Resuscitation		
Artificial Respiration (including a respirator)		
Artificial means of providing nutrition		
Artificial means of providing hydration		
_____		
_____		

Other specific requests:

_____
_____
_____
_____
_____

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

DOCUMENT OF ANATOMICAL GIFT

I make no anatomical gift at this time. _____(Initial here)
I hereby make this anatomical gift, if medically acceptable, to take effect upon my death _____(Initial here)

I give: (check one) ____ (1) any needed organs or parts ____ (2) only the following organs or parts:

_____
_____

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I,_____ appoint _____
whose address and phone number is _____ to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, **my health care representative is authorized to make any and all health care decisions for me, including the decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition and the decision to provide, withhold or withdraw life support systems**.

I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

I appoint _____whose address and phone number is_____ to be my alternative health care representative. I further instruct that as required by law my attending physician disclose to my health care representative protected health information regarding my ability to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment at the representative's request made at anytime after I sign this form.
This request is made, after careful reflection, while I am of sound mind.

Signature_____ Date_____

Print _____

This document was signed in our presence, by the above-named _____ who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time the document was signed.

Witness Signature_____Witness Signature _____

Print Name_____ Print Name _____

& Address_____ & Address_____

_____ _____

OPTIONAL(WITNESS Affidavit)

State of **Connecticut** ☐

ss._____

County of **Windham** ☐

We the undersigned, being duly sworn, depose and say:
That on this date, the within name_____, signed the foregoing living will and/or appointment of health care agent in our presence as witnesses; that we thereupon subscribed our names thereto as witnesses in (his/her) presence and at (his/her) request, and in the presence of each other; that at the time of the execution of said Advanced Directives the said_____appeared to be more than eighteen years of age and of sound mind and memory, and to the best of our judgment not under any improper restraint or influence or in any respect incompetent to make a living will and/or appoint health care agent and that we make this affidavit a (his/her) request this_____day of _____, 20_____.

Witness_____Witness _____

Subscribed and sworn to before me, on this _____day of _____, 20_____

_____
Commissioner of the Superior Court
Notary Public
My Commission Expires:_____