

District of Columbia, Maryland and Virginia  
ADVANCE DIRECTIVE

My Durable Power of Attorney for Health Care, Living Will and Other Wishes

I, (print name) \_\_\_\_\_, write this document as a directive regarding my medical care.

Put the initials of your name by the choices you want:

**PART 1. MY DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

**As long as I can make my wishes known, my doctors will talk to me and I will make my own health care decisions.**

\_\_\_\_ I appoint this person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself.

\_\_\_\_\_ name \_\_\_\_\_ home phone \_\_\_\_\_ work phone

\_\_\_\_\_ address \_\_\_\_\_

\_\_\_\_ If the person above cannot or will not make decisions for me, I appoint this person:

\_\_\_\_\_ name \_\_\_\_\_ home phone \_\_\_\_\_ work phone

\_\_\_\_\_ address \_\_\_\_\_

\_\_\_\_ I have not appointed anyone to make health care decisions for me in this or any other document. I understand that if I do not appoint a Durable Power of Attorney for Health Care, someone may be designated to make my health care decisions by law or by a court.

*I want the person I have appointed, my doctors, my family and others to be guided by the decisions I have made below:*



**PART 2. MY LIVING WILL**

These are my wishes for my future medical care if there ever comes a time when I cannot make these decisions for myself.

**A. In general, these are the goals I have for my care if I am ever seriously ill or have a serious injury (state in your own words what you believe is most important to you):**

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Put the initials of your name next to important values for you if you are ever seriously ill or have a serious injury:

- \_\_\_\_ Medicines needed to keep me pain-free
- \_\_\_\_ Ability to recognize my family / friends
- \_\_\_\_ other \_\_\_\_\_
- \_\_\_\_ other \_\_\_\_\_

**B. These are my wishes if I have a terminal condition:**

**Life-Sustaining Treatments**

\_\_\_\_ I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.

\_\_\_\_ I want life-sustaining treatments (including CPR) started on a temporary basis; if I do not show signs of recovery, then I want them stopped.

\_\_\_\_ I want life-sustaining treatments continued that my doctors think are best for me.

\_\_\_\_ Other wishes: \_\_\_\_\_

**Artificial Nutrition and Hydration:**

\_\_\_\_ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.

\_\_\_\_ I want artificial nutrition and hydration, even if it is the main treatment keeping me alive.

\_\_\_\_ Other wishes: \_\_\_\_\_

**C. These are my wishes if I am ever in a persistent vegetative state:**

**Life-Sustaining Treatments**

\_\_\_\_ I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.

\_\_\_\_\_ I want life-sustaining treatments (including CPR) started on a temporary basis; if I do not show signs of recovery, then I want them stopped.

\_\_\_\_\_ I want life-sustaining treatments continued that my doctors think are best for me.

\_\_\_\_\_ Other wishes: \_\_\_\_\_

**Artificial Nutrition and Hydration:**

\_\_\_\_\_ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.

\_\_\_\_\_ I want artificial nutrition and hydration, even if it is the main treatment keeping me alive.

\_\_\_\_\_ Other wishes: \_\_\_\_\_

**D. These are my wishes if I ever have an End-Stage Condition (including Alzheimer's or other dementia):**

**Life-Sustaining Treatments**

\_\_\_\_\_ I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.

\_\_\_\_\_ I want life-sustaining treatments (including CPR) started on a temporary basis; if I do not show signs of recovery, then I want them stopped.

\_\_\_\_\_ I want life-sustaining treatments continued that my doctors think are best for me.

\_\_\_\_\_ Other wishes: \_\_\_\_\_

**Artificial Nutrition and Hydration:**

\_\_\_\_\_ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.

\_\_\_\_\_ I want artificial nutrition and hydration, even if it is the main treatment keeping me alive.

\_\_\_\_\_ Other wishes: \_\_\_\_\_

**E. Other Directions:**

You have the right to be involved in all decisions about your medical care, even those not dealing with terminal conditions, persistent vegetative state or end-stage conditions. If you have wishes not covered in other parts of this document, please indicate them here: \_\_\_\_\_

\_\_\_\_\_

**Part 3. OTHER WISHES**

**A. Organ Donation**

\_\_\_\_\_ I do not wish to donate any of my organs or tissues.

\_\_\_\_\_ I want to donate all of my organs and tissues.

\_\_\_\_\_ I only want to donate these organs and/or tissues: \_\_\_\_\_

**B. Autopsy**

\_\_\_\_\_ I do not want an autopsy.

\_\_\_\_\_ I agree to an autopsy if my doctors wish it.

\_\_\_\_\_ Other wishes: \_\_\_\_\_

**Part 4. SIGNATURES**

You and two witnesses must sign this document in order for it to be legal.

**A. Your Signature**

By my signature below, I show that I understand the purpose and the effect of this document.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

**B. Your Witnesses' Signatures**

I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence, and that he/she appears not to be acting under pressure, duress, fraud or undue influence. I am not related to the person making this advance directive by blood marriage or adoption, nor, to the best of my knowledge, am I named in his/her will. I am not the person appointed in this advance directive. I am not a health care provider or an employee of a health care providers who is now, or has been in the past, responsible for the care of the person making this advance directive.

**Witness #1**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

**Witness #2**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_