Absence of Advance Directive

This document certifies that the individual named below has not executed an Advance Directive as of the date indicated. This statement is being provided in accordance with applicable policies and procedures regarding the absence of such directive.

Patient Name:

Date of Birth:

Date:

Provider/Witness Name:

Signature:

If at any time an Advance Directive is completed by the patient, a copy should be provided to their healthcare provider and properly documented.