Advance Healthcare Directive

Full Name: _____

Date of Birth: _____

Address: _____

1. Designation of Healthcare Agent

If I am unable to make my own healthcare decisions, I designate:

Agent Full Name: _____

Relationship: _____

Phone Number: _____

2. Instructions for Healthcare

Please specify any treatments you do or do not want (such as life support, resuscitation, or artificial nutrition):

_____

3. Organ Donation

I wish to donate my organs: ☐ Yes ☐ No

4. Signatures

Signature of Principal: _____

Date: _____

Witness 1 Signature: _____ Date: _____

Witness 2 Signature: _____ Date: _____

This document reflects my wishes regarding healthcare, and I have completed it of my own free will.