

# Attestation of No Advance Healthcare Plan

Date:

I,

, hereby declare that, to the best of my knowledge, I do not have an existing Advance Healthcare Plan (also known as an Advance Directive, Living Will, or Medical Power of Attorney) as of the date indicated above.

Address:

Date of Birth:

I understand that this attestation is made freely and voluntarily, and that I may create an Advance Healthcare Plan at any time in the future if I so choose.

Signature:

Date Signed: