Advance Directive Form

Personal Information

Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Healthcare Agent

Agent Name: _____

Relationship: _____

Phone: _____

Medical Wishes

Life Support

☐ Continue treatment

☐ Stop treatment if recovery is unlikely

CPR

☐ Yes

☐ No (DNR, if allowed)

Feeding Tube

☐ Yes

☐ No

☐ Doctor decides

Pain Relief

☐ Keep me comfortable

Organ Donation

☐ Yes

☐ No

☐ Family decides

Other Instructions

Signature

Signature: _____

Date: _____

Witnesses

Witness 1: _____

Signature: _____

Date: _____

Witness 2: _____

Signature: _____

Date: _____

Notary (If Required)

Notary Signature: _____

Date: _____

Seal: _____