

INSTRUCTIONS

**MAINE
ADVANCE HEALTH CARE DIRECTIVE**

EXPLANATION

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. You may complete or modify all or any part of the following form or use a different form.

A copy of this form has the same effect as the original.

SECTION I

POWER OF ATTORNEY FOR HEALTH CARE

**PRINT YOUR
NAME**

(1) DESIGNATION OF AGENT: I, _____
appoint the following person as my agent to make health care decisions
for me:

**PRINT THE
NAME,
ADDRESS, AND
TELEPHONE
NUMBERS OF
YOUR PRIMARY
AGENT**

(name of agent)

(address)

_____ *(city)* _____ *(state)* _____ *(zip code)*

_____ *(home phone)* _____ *(work phone)*

If I revoke the authority of my agent or if my agent is not willing, able, or reasonably available to make health care decisions for me, I designate as my alternate agent:

(name of first alternative agent)

(address)

(city) *(state)* *(zip code)*

(home phone) *(work phone)*

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health care decision for me, I designate as my second alternate:

(name of second alternative agent)

(address)

(city) *(state)* *(zip code)*

(home phone) *(work phone)*

(2) AGENT'S AUTHORITY: My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, **except** as I state here:

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR FIRST ALTERNATIVE AGENT

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR SECOND ALTERNATIVE AGENT

ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

CROSS OUT AND INITIAL ANY STATEMENTS WITHIN THE FOLLOWING PARAGRAPHS THAT DO NOT REFLECT YOUR WISHES

[CHECK THE BOX IN PARAGRAPH (4) ONLY IF YOU WANT YOUR AGENT'S AUTHORITY TO TAKE EFFECT IMMEDIATELY]

INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT

(3) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Section II of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(4) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box , my agent's authority to make health care decisions for me takes effect immediately.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

SECTION II

INSTRUCTIONS FOR HEALTH CARE

(6) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

I Choose NOT To Prolong Life: I do not want my life to be prolonged if (i) I have an incurable or irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, **OR**

I Choose To Prolong Life: I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

INITIAL YOUR
PREFERENCE
REGARDING
ARTIFICIAL
NUTRITION AND
HYDRATION

(7) ARTIFICIAL NUTRITION AND HYDRATION: I also specify that under the conditions mentioned in the above paragraph:

___ I **do not** want artificial nutrition and hydration provided to me in order to prolong my life.

___ I **do** want artificial nutrition and hydration provided to me in order to prolong my life.

ADD PERSONAL
INSTRUCTION
ONLY IF YOU
DISAGREE WITH
THE STATEMENT
IN PARAGRAPH
(8)

(8) RELIEF FROM PAIN OR DISCOMFORT: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

PRINT ANY
ADDITIONAL
INSTRUCTIONS
THAT WILL
GUIDE YOUR
HEALTH CARE
PROVIDER(S)
AND AGENT

(9) OTHER HEALTH CARE INSTRUCTIONS OR WISHES:

(OPTIONAL)

SECTION III

DESIGNATION OF PRIMARY PHYSICIAN

(10) I designate the following physician as my primary physician:

**PRINT THE
NAME,
ADDRESS, AND
TELEPHONE
NUMBER OF
YOUR PRIMARY
PHYSICIAN**

(name of physician)

(address)

(city)

(state)

(zip code)

(phone)

SECTION IV

DONATION OF ORGANS AT DEATH

(OPTIONAL)

(11) UPON MY DEATH:

___ I give any needed organs, tissues or parts, **or**

___ I give **only** the following organs, tissues or part:

**INITIAL THE
SENTENCE
THAT BEST
REFLECTS
YOUR WISHES**

(12) MY GIFT IS FOR THE FOLLOWING PURPOSES:

(i) Transplant

(ii) Therapy

(iii) Research

(iv) Education

**INITIAL THE
PURPOSES
THAT REFLECT
YOUR WISHES**

SIGNATURE

**PRINT YOUR
NAME,
ADDRESS, AND
SOCIAL
SECURITY
NUMBER, AND
THEN SIGN AND
DATE THE
DOCUMENT**

(name)

(address)

(social security number - optional)

(date)

(signature)

WITNESSES

**HAVE YOUR
WITNESS SIGN
AND DATE THE
DOCUMENT,
AND THEN
PRINT THEIR
NAMES AND
ADDRESS**

(signature of first witness)

(date)

(printed name of first witness)

(address of first witness)

(signature of second witness)

(date)

(printed name of second witness)

(address of second witness)