I, , voluntarily executed the following advance directive while being of sound mind.

If I am unable to participate in medical treatment decisions, I designate the individual below as my medical power of attorney:

First Name:

Last Name:

Address:

Main Phone:

Alternate Phone:

Email Address:

Here are my answers to the following questions regarding treatment preferences:

Question 1: Would you want CPR to be performed if your heart or breathing stopped?

Response 1:

Question 2: Would you want to receive medications if your heart can't get enough blood to your organs?

Response 2:

Question 3: Would you want to be connected to a ventilator if you were unable to breathe on your own?

Response 3:

Question 4: Would you want to receive tube feeding if you were unable to eat on your own?

Response 4:

Question 5: Would you want to receive dialysis treatment if your kidneys stopped working on their own?

Response 5:

Consider these values:

Consider these messages:

My physician will determine when I am unable to participate in medical treatment decisions. At such time, I request that the choices expressed within this form be followed. Should any part of this form be legally

ineffective, please follow all other parts of this document.

Electronic Signature:

Electronic Signature Date:

Address:

Phone:

Legal

Witnesses are recommended to further enforce your decisions. AdirNow is meant as a healthcare planning tool. It is not meant to give you legal advice. Laws change from time to time, and your state may have certain rules concerning how to legally enforce your advance directive. We always recommend you speak with a medical or legal professional for advice.

Handwritten Signature (in presence of witnesses): _____

Signature Date: _____

Acceptance by Patient Advocate

(1) This designation shalt not become effective unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable. If this patient advocate designation includes the authority to make an anatomical gift as described in section 5506, the authority remains exercisable after the patient's death.

(2) A patient advocate shall not exercise powers concerning the patient's care, custody and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.

(3) This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

(4) A patient advocate may make a decision to withhold or withdraw treatment which would allow a patient to die only if the patient has expressed in a clear md convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

(5) A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

(6) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental health treatment decisions are presumed to be in the patient's best interests.

(7) A patient may revoke his or her designation at any time or in any mariner sufficient to communicate an intent to revoke.

(8) A patient may waive his or her right to revoke the patient advocate designation as to the power to make mental health treatment decisions, and if such waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

(9) A patient advocate may revoke his or her acceptance to the designation at airy time and in any manner sufficient to communicate an intent to revoke.

(10) A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, Being Section 333.20201 of the Michigan Compiled Laws.

I, _____ (Name of patient advocate), understand the above conditions and I accept the designation as patient advocate or successor patient advocate for _____ (Name of patient), who signed a durable power of attorney for health care on the following date: _____

Dated: _____

Signed: _____
(Signature of patient advocate or successor patient advocate)

Witness Statement:

I, the witness, declare under penalty of perjury under the laws of the state of _____, that the individual named above, who completed this advance directive, is personally known to me, that the individual signed or acknowledged this form in my presence and he/she appeared to be of sound mind and under no duress, fraud, or undue influence. I declare that I am at least eighteen (18) years of age and:

- Not someone who signed on the individual’s behalf
- Not a healthcare provider, the individuals attending physician or otherwise
- Not designated as the individual’s healthcare proxy or alternate
- Not related to the individual by blood, marriage, or adoption
- Not entitled to any portion of the individual’s estate, either through his/her will or codicil thereto existing at the time of execution, or under the laws of intestate succession
- Not have a claim against the individual’s estate
- Not directly financially responsible for the individual's healthcare
- Not an employee, owner, or operator of a healthcare facility
- Not an employee, owner of operator of a residential care facility for the elderly
- Not an employee of the individual’s life insurance provider or health insurance provider

Witness Number 1: _____

Printed Name: _____

Signature: _____

Date: _____

Witness Number 2: _____

Printed Name: _____

Signature: _____

Date: _____

Notarization*

State of _____ County of _____

On this _____ day of _____, 20_____, the said _____,

_____, and _____, known to me, or satisfactorily proven to be the person named in the foregoing instrument and witnesses, respectively, personally, appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

My commission expires: _____ Notary Public: _____

*Speak to a legal professional to find out more information