

*Advance Directive and Durable Power of Attorney*  
Advance Health Care Directive

State of Delaware

The Rest of Your Life recommends that you review completed documents with an attorney, especially if there are mitigating circumstances surrounding your Advance Directive or Durable Power of Attorney.

### Advance Directives Electronic Forms

The ROYL is a leader in offering electronic Advance Directive documents for digital signatures. Electronic Advance Directive Forms are secure and accessible anytime from any device that allows for Internet access.

### Why do an Advance Directive?

Anyone 18 years of age or older should have an Advance Directive. This document allows for the care you have designated to be respected and followed through in the event you cannot speak for yourself. It allows for you to name someone to speak on your behalf, but most importantly it removes the stress, anxiety and guilt from decisions that your loved ones would otherwise have to make on your behalf.

An Advance Directive is not just for aging people. The cases of Teri Shivo and Karen Ann Quinlan serve as examples of how any adult, regardless of age, can benefit from having one. Both young adults, Shivo and Quinlan were kept alive by machines for years because they did not tell or write down what they wanted in the event of a tragic accident. The court battles that ensued took not only an emotional toll, but required government involvement because of disagreements between spouses and family members.

### Description:

An Advance Directive, sometimes referred to as a Living Will or an Advance Health Care Directive, allows you to make your wishes known if you are unable to speak for yourself. An Advance Directive provides you and your loved ones with peace of mind that your care is compatible with your wishes. This is truly a gift to those you love as it helps them clearly know what to do in this stressful situation.

Advance Directive requirements vary from state to state. You can download the appropriate state form here at no cost prior to completing the form online so that you have the required information prepared in advance.

### Security:

Your documents are processed using DocuSign, the leader in global electronic signature and document security.

When you complete your Advance Directive with The ROYL, you can download it as a PDF file to your computer's hard drive. DocuSign will email a final copy to the designees in your Advance Directive. We recommend you print a hard copy and send it via email or mail to others you want to have copies.

Contact us if you have questions in preparing the forms selected.

**NOTICE: You must have the required information available prior to initiating the document (designees, contact information, wishes for care).**

**Advance Health Care Directive**  
**In Process**  
of

EXAMPLE

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**This form was developed by the Committee on Law and the Elderly of the Delaware Bar Association and approved for use by the Office of the Attorney General of the State of Delaware.**

## GENERAL INSTRUCTIONS

You should read this form carefully before filling it in. You should fill it in completely. If there are health care decisions you do not want to make, you should strike the wording of that decision rather than leave it blank. You may not change the qualifications for witnesses or agents, even if you cross out the wording. You should write legibly.

After you have filled out the form completely, you should sign the form before a notary public. Although signing before a notary public is not legally required, it is advisable. It is advisable because the notary, as well as your witnesses, can testify as to your competence when you sign the directive, if your competence becomes an issue. Notaries, who are registered with the State, are often easier to locate later than witnesses.

You should retain your original Advance Health care Directive, and give copies to your doctor, agent, spouse, family members, and close friends, if you desire. You should explain to each person who receives a copy of your health care directive what choices you made on the form, and why. This will help if, while you lack competence, there arises a need to make a health care decision that is not explicitly set forth on your advance health care directive form.

This form does not contain all of the types of health care decisions you are legally entitled to make. For example, the form does not give you the opportunity to nominate a guardian, in the event you become incompetent and need one. Also, the form does not give you the opportunity to designate a primary care physician, or another person, to certify that you lack the capacity to make your own decisions on health care. Finally, the form does not include a provision that accommodates a person's religious or moral beliefs. If you would like to exercise these options, you should talk to an attorney. If anything on the form conflicts with your religious beliefs, you should contact your clergy.

### PART I. INSTRUCTIONS FOR HEALTH CARE DECISIONS

If you are an adult who is mentally competent, you have the right to accept or refuse medical or surgical treatment, if such refusal is not contrary to existing public health laws. You may give advance instructions for medical or surgical treatment that you want or do not want. These instructions will become effective if you lose the capacity to accept or refuse medical or surgical treatment. You may limit your instructions to take effect only if you are in a specified medical condition. If you give an instruction that you do not want your life prolonged, that instruction will only take effect if you are in a "qualifying condition." A "qualifying condition" is either a terminal condition or permanent unconsciousness.

If you want to give instructions to accept or refuse medical or surgical treatment, you should fill in the spaces on the following page. You may cross out any wording you do not want.

**A. END OF LIFE INSTRUCTIONS**

1. Choice To Prolong Life

\_\_\_\_\_ I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

**OR**

2. Choice Not To Prolong Life

I do not want my life to be prolonged if (please check all that apply)

\_\_\_\_\_ (i) I have a terminal condition (an incurable condition from which there is no reasonable medical expectation of recovery and which will cause my death, regardless of the use of life-sustaining treatment). In this case, I give the specific directions indicated:

	I want used	I do not want used
Artificial nutrition through a conduit	_____	_____
Hydration through a conduit	_____	_____
Cardiopulmonary resuscitation	_____	_____
Mechanical respiration	_____	_____
Other (explain) _____	_____	_____
_____		

\_\_\_\_\_ (ii) I become permanently unconscious (a medical condition that has existed at least four (4) weeks and has been diagnosed in accordance with currently accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma) and regarding the following, I give the specific directions indicated:

	I want used	I do not want used
Artificial nutrition through a conduit	_____	_____
Hydration through a conduit	_____	_____
Cardiopulmonary resuscitation	_____	_____
Mechanical respiration	_____	_____
Other (explain) _____	_____	_____
_____		

**B. RELIEF FROM PAIN:** Whether I choose A.1 or A.2, or neither, I direct that in all cases I be given all medically appropriate care necessary to make me comfortable and alleviate pain.

**C. OTHER MEDICAL INSTRUCTION:** If you wish to add to the instructions you have given above, you may do so here.

\_\_\_\_\_

\_\_\_\_\_

*(use additional sheets if necessary)*

**PART II: POWER OF ATTORNEY FOR HEALTH CARE**

Your agent may make any health care decision that you could have made while you had the capacity to make health care decisions. You may appoint an alternate agent to make health care decisions for you if your first agent is not willing, able and reasonably available to make decisions for you. Unless the persons you name as agent and alternate agent are related to you by blood, neither may own, operate or be employed by any residential long-term care institution where you are receiving care.

If you wish to appoint an agent to make health care decisions for you under these circumstances and conditions, you must fill out the section below. You may cross out any wording you do not want.

**A. DESIGNATION OF AGENT:** I designate EXAMPLE  
as my agent to make health care decisions for me. If he/she is not living, willing or able, or reasonably available, to make health care decisions for me, then I designate \_\_\_\_\_  
\_\_\_\_\_ as my agent to make health care decisions for me.

\_\_\_\_\_  
(name of individual you choose as agent)

\_\_\_\_\_  
(address) (city) (state) (zip code)

\_\_\_\_\_  
(home phone) (work phone)

\_\_\_\_\_  
(name of individual you choose as alternate agent)

\_\_\_\_\_  
(address) (city) (state) (zip code)

\_\_\_\_\_  
(home phone) (work phone)

**B. AGENT'S AUTHORITY:** I grant to my agent full authority to make decisions for me regarding my health care; provided that, in exercising this authority, my agent shall follow my desires as stated in this document or otherwise known to my agent. Accordingly, my agent is authorized as follows:

1. To consent to, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function;
2. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;
3. To authorize my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service;
4. To contract for any health care related service or facility on my behalf, without my agent incurring personal financial liability for such contracts;
5. To hire and fire medical, social service, and other support personnel responsible for my care; and

6. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death.

**C. WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE:** My agent’s authority becomes effective when my attending physician determines I lack the capacity to make my own health care decisions.

**D. 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 Part I of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, health care decisions by my agent shall conform as closely as possible to what I would have done or intended under the circumstances. If my agent is unable to determine what I would have done or intended under the circumstances, my agent will make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

**PART III. ANATOMICAL GIFT DECLARATION (Optional)**

I hereby make the following anatomical gift(s) to take effect upon my death. The marks in the appropriate squares and words filled into the blanks below indicate my desires:

I give  my body;  any needed organs or parts;  
 the following organs or parts \_\_\_\_\_

to  the physician in attendance at my death;  the hospital in which I die;  
 the following named physician, hospital, storage bank or other medical institution  
\_\_\_\_\_

for the following purpose(s):

- any purpose authorized by law;  transplantation;
- therapy;  research;
- medical education.

**EFFECT OF COPY:** A copy of this form has the same effect as the original.

I understand the purpose and effect of this document.

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(sign your name)

\_\_\_\_\_  
(print your name)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city) (state) (zip code)

**STATEMENT OF WITNESSES**

SIGNED AND DECLARED by the above-named declarant as and for his/her written declaration under 16 Del.C. §§ 2502, 2503, in our presence, who in his/her presence, at his/her

request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state:

- A. The Declarant is mentally competent.
- B. That neither of us is prohibited by §2503 of Title 16 of the Delaware Code from being a witness. Neither of us:
  - 1. Is related to the declarant by blood, marriage or adoption;
  - 2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the executing of the advance health care directive, is so entitled by operation of law then existing;
  - 3. Has, at the time of the execution of the advance health care directive, a present or inchoate claim against any portion of the estate of the declarant;
  - 4. Has a direct financial responsibility for the declarant's medical care;
  - 5. Has a controlling interest in or is an operator or an employee of a health care institution in which the declarant is a patient or resident; or
  - 6. Is under eighteen years of age.
- C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses, \_\_\_\_\_, is at the time of the execution of the advance health care directive, a patient advocate or ombudsman designated by the Division of Services for Aging and Adults with Physical Disabilities or the Public Guardian.

Witness

Witness

\_\_\_\_\_  
(print name)

\_\_\_\_\_  
(print name)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(address)

\_\_\_\_\_  
(city, state, zip code)

\_\_\_\_\_  
(city, state, zip code)

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(date)

\_\_\_\_\_  
(signature of witness)

\_\_\_\_\_  
(date)

**(Optional)**

Sworn and subscribed to me this \_\_\_\_\_ day of \_\_\_\_\_.

My term expires: \_\_\_\_\_

\_\_\_\_\_  
(Notary)



# *A letter to my loved ones...*

*Dear Loved Ones,*

*I want the best quality of life possible during my last days.  
Therefore, I hereby request as follows...*

(a) I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering as possible. Please consult with my doctor in this regard.

(b) If my temperature is above normal, I want a cool moist cloth put on my head.

(c) I want my mouth and lips kept moist.

(d) I need to be kept fresh and clean at all times. I wish to have warm baths often or warm showers, if I am stable enough for a shower.

(e) I desire to be massaged with or without warm oils as often as you think will help maintain my skin integrity and provide for my comfort.

(f) I want my personal care such as nail clipping, hair combing, teeth brushing and shaving as long as they do not cause me pain.



*I hope my family and friends would consider that...*

(a) I enjoy your company and want you with me when possible. I desire that one of you stay with me when it seems that my death may be imminent.

(b) Please continue to talk to me about daily happenings and events, even if you think I don't understand, because I might be able to understand.

(c) Please don't be afraid to hold my hand or hug me.

(d) Please tell the members of my church or synagogue I am sick and ask them to pray for me and visit me.

(e) Please maintain a cheerful atmosphere around me.

(f) Please place pictures of my loved ones in my room, near my bed, or near the place I sit during the day.

(g) My clothes and bed linens are to be kept clean, and they are to be changed as soon as possible, if they have been soiled.

(h) If at all possible, allow me to die in my home.

(i) Please arrange for me to watch television or listen to my favorite sports events.

(j) Let me enjoy the outdoors as often as possible by letting me spend time in my yard, garden and other appropriate outdoor places, even if it causes slight discomfort to either you or me.

(k) I want to have my favorite types of music played when possible.

(l) I want to have religious readings read to me when I am near death.

(m) I want to have my favorite poems read to me from time to time.

*I want you to know the following about my thoughts and concerns, if I am disabled and cannot convey these thoughts to you verbally...*

- (1) I want you to know that I love you.
- (2) I would like to be forgiven for the times I have hurt you.
- (3) I forgive you for what you may have done to me in my life.
- (4) I want you to know that I do not fear death itself.
- (5) I want all of my family members to recommit their love for one another.
- (6) Please remember me the way I was before I had a terminal illness.
- (7) Please help me maintain meaning to my life during this process of dying by realizing that this is an opportunity for personal growth for all.
- (8) Don't be afraid to seek counseling, if you have trouble with my death.

*If friends want to know how I want to be remembered, tell them the following...*

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*The following person(s) know my funeral plans...*

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3 of 4 Principal \_\_\_\_\_

*At any memorial service for me, I want to include the following music, songs, readings or other plans for such a service...*

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*I also have the following requests...*

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*In Process*

**These are requests of my family members, loved ones, and friends, and are not to be considered legal directives to my attorney-in-fact for health care, if any.**

*(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)*

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

4 of 4 Principal \_\_\_\_\_

**Additional Pages:**

In Process

In Process