

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 DIRECTIVE

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

This is an important legal document. It can control critical decisions about your health care. Before signing, consider these important facts:

Facts About PART B (Appointing a Health Care Representative)

You have the right to name a person to direct your health care when you cannot do so. This person is called your “health care representative.” You can do this by using PART B of this form. Your representative must accept on PART E of this form.

In this document, you can write any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts About PART C (Giving Health Care Instruction)

You also have the right to give instructions for health care providers to follow if you become unable to direct your care. You can do this by using PART C of this form.

Facts About Completing This Form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this directive, it will not expire. If you have set an expiration date, and you become unable to direct your health care before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation.

Despite this document, you have the right to decide your own health care as long as you are able to do so.

If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that don’t express your wishes or add words that better express your wishes. Witnesses must sign PART D.

Print your NAME, BIRTHDATE, and ADDRESS here:

EXAMPLE

(Name)

(Birthdate)

(Address)

Unless revoked or suspended, this advance directive will continue for:

INITIAL ONE:

_____ My entire life

_____ Other period (_____ Years)

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint _____ as my health care representative.

My representative's address is _____

and telephone number is _____.

I appoint _____ as my alternate health care

representative. My alternate's address is _____

and telephone number is _____.

I authorize my representative (or alternate) to direct my health care when I can't do so.

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator or employee of your health care facility, unless that person is related to you by blood, marriage or adoption, or that person was appointed before your admission into the health care facility.

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE (CONTINUED)

1. Limits.

Special Conditions or Instructions: _____

INITIAL IF THIS APPLIES:

_____ I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

2. Life Support.

“Life support” refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

INITIAL IF THIS APPLIES:

_____ My representative MAY decide about life support for me. (If you don’t initial this space, then your representative MAY NOT decide about life support.)

3. Tube Feeding.

One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

INITIAL IF THIS APPLIES:

_____ My representative MAY decide about tube feeding for me. (If you don’t initial this space, then your representative MAY NOT decide about tube feeding.)

(Date)

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

(Signature of person making appointment)

PART C: HEALTH CARE INSTRUCTIONS

NOTE: In filling out these instructions, keep the following in mind:

- The term “as my physician recommends” means that you want your physician to try life support if your physician believes it could be helpful and then discontinue it if it is not helping your health condition or symptoms.
- “Life support” and “tube feeding” are defined in PART B above.
- If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.
- You will get care for your comfort and cleanliness, no matter what choices you make.
- You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

1. Close to Death. If I am close to death and life support would only postpone that moment of my death:

A. INITIAL ONE:

- _____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I DO NOT WANT tube feeding.

B. INITIAL ONE:

- _____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want NO life support.

2. Permanently Unconscious. If I am unconscious and it is very unlikely that I will ever become conscious again:

A. INITIAL ONE:

- _____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I DO NOT WANT tube feeding.

B. INITIAL ONE:

- _____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want NO life support.

PART C: HEALTH CARE INSTRUCTIONS (CONTINUED)

- 3. Advanced Progressive Illness. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

A. INITIAL ONE:

- I want to receive tube feeding.
- I want tube feeding only as my physician recommends.
- I DO NOT WANT tube feeding.

B. INITIAL ONE:

- I want any other life support that may apply.
- I want life support only as my physician recommends.
- I want NO life support.

- 4. Extraordinary Suffering. If life support would not help my medical condition and would make me suffer permanent and severe pain:

A. INITIAL ONE:

- I want to receive tube feeding.
- I want tube feeding only as my physician recommends.
- I DO NOT WANT tube feeding.

B. INITIAL ONE:

- I want any other life support that may apply.
- I want life support only as my physician recommends.
- I want NO life support.

- 5. General Instruction.

INITIAL IF THIS APPLIES:

I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

- 6. Additional Conditions or Instructions. (Insert description of what you want done.)

PART C: HEALTH CARE INSTRUCTIONS (CONTINUED)

7. Other Documents. A “health care power of attorney” is any document you may have signed to appoint a representative to make health care decisions for you.

INITIAL ONE:

_____ I have previously signed a health care power of attorney. I want it to remain in effect unless I appointed a health care representative after signing the health care power of attorney.

_____ I have a health care power of attorney, and I REVOKE IT.

_____ I DO NOT have a health care power of attorney.

(Date)

SIGN HERE TO GIVE INSTRUCTIONS

(Signature)

In Process

PART D: DECLARATION OF WITNESSES

We declare that the person signing this advance directive:

- (a) Is personally known to us or has provided proof of identity;
- (b) Signed or acknowledged that person’s signature on the advance directive in our presence;
- (c) Appears to be of sound mind and not under duress, fraud or undue influence;
- (d) Has not appointed either of us as health care representative or alternative representative;
- and
- (e) Is not a patient for whom either of us is attending physician.

Witnessed By:

(Signature of Witness/Date) (Printed Name of Witness)

(Signature of Witness/Date) (Printed Name of Witness)

NOTE: One witness must not be a relative (by blood, marriage or adoption) of the person signing this advance directive. That witness must also not be entitled to any portion of the person’s estate upon death. That witness must also not own, operate or be employed at a health care facility where the person is a patient or resident.

~~PART C: HEALTH CARE INSTRUCTIONS (CONTINUED)~~
~~PART E: ACCEPTANCE BY HEALTH CARE REPRESENTATIVE~~

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document allows me to decide about that person's health care only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider if known to me.

(Signature of Health Care Representative/Date)

(Printed Name)

In Process

(Signature of Alternate Health Care Representative/Date)

(Printed Name)



PART C: HEALTH CARE INSTRUCTIONS (CONTINUED)

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.

PART C: HEALTH CARE INSTRUCTIONS (CONTINUED)

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.

PART C: HEALTH CARE INSTRUCTIONS (CONTINUED)

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...

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

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

I also have the following requests...

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 EXAMPLE

4 of 4 *Principal* _____