

PowerForm Signer Information

Please enter your name and email to begin the signing process.

Your Role:

Originator

Your Name:

Your Email:

Please provide information for any other signers needed for this document.

Role:

Witness 1

Name:

Email:

Role:

Witness 2

Name:

Email:

Role:

Physician

Name:

Email:

[Begin Signing](#)

If there are other roles required for this document to be completed, please enter the name and email of those other recipients. An email will be sent inviting them to sign along with you.

**MARYLAND ADVANCE DIRECTIVE:
PLANNING FOR FUTURE HEALTH CARE DECISIONS**

By: EXAMPLE _____ Date of Birth: _____
(Print Name) (Month/Day/Year)

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. **Make sure you talk to your health care agent (and any back-up agents) about this important role.** Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that too.

+ You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive.

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

PART I: SELECTION OF HEALTH CARE AGENT

A. Selection of Primary Agent

I select the following individual as my agent to make health care decisions for me:

Name: _____

Address: _____

Telephone Numbers: _____
(home and cell)

B. Selection of Back-up Agents

(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____

Address: _____

Telephone Numbers: _____

(home and cell)

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____

Address: _____

Telephone Numbers: _____

(home and cell)

In Process

C. Powers and Rights of Health Care Agent

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;
2. Decide who my doctor and other health care providers should be; and
3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.
4. I also want my agent to:
 - a. Ride with me in an ambulance if ever I need to be rushed to the hospital; and
 - b. Be able to visit me if I am in a hospital or any other health care facility.

THIS ADVANCE DIRECTIVE DOES NOT MAKE MY AGENT RESPONSIBLE FOR ANY OF THE COSTS OF MY CARE.

This power is subject to the following conditions or limitations:
(Optional; form valid if left blank)

D. How my Agent is to Decide Specific Issues

I trust my agent’s judgment. My agent should look first to see if there is anything in Part II of this advance directive that helps decide the issue. Then, my agent should think about the conversations we have had, my religious and other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

E. People My Agent Should Consult
(Optional; form valid if left blank)

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent’s power to make decisions.

Name(s)

Telephone Number(s):

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

F. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my agent shall follow these specific instructions:

G. Access to my Health Information – Federal Privacy Law (HIPAA) Authorization

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.
2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.
3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

H. Effectiveness of this Part

(Read both of these statements carefully. Then, initial one only.)

My agent's power is in effect:

1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

>>OR<<

2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability **temporarily**, or my attending physician and a consulting doctor agree that I have lost this ability **permanently**.

If the only thing you want to do is select a health care agent, skip Part II. Go to Part III to sign and have the advance directive witnessed. If you also want to write your treatment preferences, go to Part II. Also consider becoming an organ donor, using the separate form for that.

PART II: TREATMENT PREFERENCES (“LIVING WILL”)

A. Statement of Goals and Values

(Optional: Form valid if left blank)

I want to say something about my goals and values, and especially what’s most important to me during the last part of my life:

B. Preference in Case of Terminal Condition

(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that my death from a terminal condition is imminent, even if life-sustaining procedures are used:

- 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

>>OR<<

- 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

>>OR<<

- 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

C. Preference in Case of Persistent Vegetative State

(If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

- 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

>>OR<<

- 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

>>OR<<

- 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

D. Preference in Case of End-Stage Condition

(If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in an end-state condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

- 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

>>OR<<

- 2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

>>OR<<

- 3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

E. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

F. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

G. Effect of Stated Preferences

(Read both of these statements carefully. Then, initial one only.)

- 1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

>>OR <<

- 2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

PART III: SIGNATURE AND WITNESSES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

(Signature of Declarant) _____
(Date)

The Declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

In Process

(Signature of Witness) _____
(Date)

Telephone Number(s):

(Signature of Witness) _____
(Date)

Telephone Number(s):

(Note: Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant’s death. Maryland law does **not** require this document to be notarized.)

AFTER MY DEATH
(This document is optional. Do only what reflects your wishes.)

By: EXAMPLE Date of Birth: _____
(Print Name) (Month/Day/Year)

PART I: ORGAN DONATION

(Initial the ones that you want. Cross through any that you do not want.)

Upon my death I wish to donate:

Any needed organs, tissues, or eyes. —

Only the following organs, tissues, or eyes: —

In Process

I authorize the use of my organs, tissues, or eyes:

For transplantation —

For therapy —

For research —

For medical education —

For any purpose authorized by law —

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead. *This document is not intended to change anything about my health care while I am still alive.* After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

PART II: DONATION OF BODY

After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program.

PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS

I want the following person to make decisions about the disposition of my body and my funeral arrangements: (Either initial the first or fill in the second.)

The health care agent who I named in my advance directive.

>>OR<<

This person:

Name: _____

Address: _____

Telephone Number(s): _____
(Home and Cell)

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

PART IV: SIGNATURE AND WITNESSES

By signing below, I indicate that I am emotionally and mentally competent to make this donation and that I understand the purpose and effect of this document.

(Signature of Donor)

(Date)

The Donor signed or acknowledged signing the foregoing document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.

(Signature of Witness)

(Date)

Telephone No: _____

(Signature of Witness)

(Date)

Telephone No: _____

Did You Remember To ...

- G Fill out Part I if you want to name a health care agent?
- G Name one or two back-up agents in case your first choice as health care agent is not available when needed?
- G Talk to your agents and back-up agent about your values and priorities, and decide whether that's enough guidance or whether you also want to make specific health care decisions in the advance directive?
- G If you want to make specific decisions, fill out Part II, choosing carefully among alternatives?
- G Sign and date the advance directive in Part III, in front of two witnesses who also need to sign?
- G Look over the "After My Death" form to see if you want to fill out any part of it?
- G Make sure your health care agent (if you named one), your family, and your doctor know about your advance care planning?
- G Give a copy of your advance directive to your health care agent, family members, doctor, and hospital or nursing home if you are a patient there?



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.

1 of 4 Principal _____

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.

2 of 4 Principal _____

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 _____