PART ONE: APPOINTMENT OF HEALTH-CARE REPRESENTATIVE AND POWER OF ATTORNEY

PRINT YOUR NAME AND ADDRESS

I, _____
(name)

of _____
(address)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR HEALTH-CARE REPRESENTATIVE

hereby appoint _____
(name of health-care representative)

_____
(address)

_____
(home telephone number) (work telephone number)

as my health-care representative — and attorney-in-fact, if I have had this document notarized on page 7 — ("health-care representative") to make health-care decisions on my behalf whenever I am incapable of making my own health-care decisions.

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR SUCCESSOR HEALTH-CARE REPRESENTATIVE

In the event the person I appoint above is unable, unwilling or unavailable to act as my health-care representative, I hereby appoint:

_____
(name of successor health-care representative)

of _____
(address)

_____

_____
(home telephone number) (work telephone number)

as my successor health-care representative.

PART ONE: APPOINTMENT OF HEALTH-CARE REPRESENTATIVE AND POWER OF ATTORNEY (Continued)

Powers Granted to my Health-Care Representative

I grant my health-care representative all powers available under Indiana Code, Title 16, Article 36, Chapter 1 to make health-care decisions for me in the event I am unable to make such decisions myself. These powers include, but are not limited:

(1) to consent to or refuse health care for me;
(2) to admit or release me from a hospital or health-care facility; and
(3) to have access to my records, including medical records, concerning my condition.

THESE POWERS CAN BE GRANTED TO YOUR HEALTH-CARE REPRESENTATIVE WITHOUT HAVING A NOTARY PUBLIC WITNESS YOUR SIGNATURE

I understand health care to include any medical care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental well-being. Health care also includes the providing of nutrition and hydration through intravenous, gastrostomy, or nasogastric tubes.

I authorize my health-care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis, my health-care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health-care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health-care representative must try to discuss this decision with me. However, if I am unable to communicate, my health-care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health-care givers. To the extent appropriate, my health-care representative may also discuss this decision with my family and others to the extent they are available.

PART ONE: APPOINTMENT OF HEALTH-CARE REPRESENTATIVE AND POWER OF ATTORNEY (Continued)

Additional Powers Granted to my Health-Care Representative as my Attorney-in-Fact (Notary Required)

IN ORDER TO GRANT YOUR HEALTH-CARE REPRESENTATIVE THESE ADDITIONAL POWERS TO SERVE AS YOUR ATTORNEY-IN-FACT, YOU MUST HAVE YOUR SIGNATURE WITNESSED BY A NOTARY PUBLIC ON PAGE 7 OF THIS FORM

If my signature of this document is witnessed by a notary public, I further grant my health-care representative all powers available as my attorney-in-fact under Indiana Code §§ 30-5-5-16 and 30-5-5-17 to make health-care decisions for me in the event I am unable to make such decisions myself, including, but not limited to:

(1) to employ or contract with servants, companions, or health care providers involved in my health care;
(1) to make anatomical gifts on my behalf;
(3) to request an autopsy; and
(4) to make plans for the disposition of my body.

Revocation of Health-Care Representative's Power and Appointment

REVOCATION OPTIONS

YOU MAY REVOKE ALL POWERS GRANTED TO YOUR HEALTH-CARE REPRESENTATIVE IN THIS FORM, INCLUDING THOSE AS YOUR ATTORNEY-IN-FACT, AS DESCRIBED HERE

I may revoke the authority of my health-care representative, including any powers granted to my health-care representative as my attorney-in-fact, and all of the powers granted in this document, whenever I am capable of consenting to health care by notifying my health-care provider or my health-care representative orally or in writing.

I may revoke the appointment of my health-care representative, and all of the powers granted in this document, whenever I am capable of consenting to health care by notifying my health-care representative orally or in writing.

PART ONE: APPOINTMENT OF HEALTH-CARE REPRESENTATIVE AND POWER OF ATTORNEY (Continued)

Guidance for my Health-Care Representative

When making health-care decisions for me, my health-care representative should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in Part Two (if I have filled out Part Two), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health-care representative should make decisions for me that my health-care representative believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

In addition, my health-care representative should consider the following instructions in making health-care decisions on my behalf: (attach additional pages if needed.)

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

PART TWO: DECLARATION

PRINT THE DATE

Declaration made this _____ day of _____.
(day) (month, year)

PRINT YOUR NAME

I, _____,
(name)

being at least eighteen (18) years old and of sound mind, willfully and voluntarily exercise my right to determine the course of my health care and to provide clear and convincing proof of my treatment decisions. If at any time I have an incurable injury, disease, or illness determined to be a terminal condition and am unable to make decisions, I declare that:

INITIAL ONLY ONE OF THE FOLLOWING TWO CHOICES

INITIAL HERE IF YOU WANT LIFE-PROLONGING PROCEDURES UNDER ALL CIRCUMSTANCES

_____ (Life-Prolonging Procedures Declaration) I want the use of life-prolonging procedures that would extend my life under all circumstances. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

INITIAL HERE IF YOU WANT LIFE-PROLONGING PROCEDURES WITHHELD OR WITHDRAWN UNDER THE CONDITIONS LISTED

_____ (Living Will Declaration) I request that my dying shall not be artificially prolonged. If my death will occur within a short time and the use of life prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialing or making your mark before signing this declaration):

IF YOU INITIALED THE LIVING WILL DECLARATION ABOVE, INITIAL THE STATEMENT THAT REFLECTS YOUR WISHES ABOUT ARTIFICIAL NUTRITION (FEEDING) AND HYDRATION (FLUIDS)

____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health-care representative appointed under Indiana Code 16-36-1-7 or my attorney-in-fact with health-care powers under Indiana Code 30-5-5.

PART TWO: DECLARATION (Continued)

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

I further declare that: (add additional instructions, if any, adding additional pages, if needed.)

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal. My health-care representative, under Indiana Code 16-36-1-7 or my attorney-in-fact, under Indiana Code 30-5-5, if I have appointed one, is responsible for interpreting this declaration if there is a disagreement as to its applicability.

PART THREE: EXECUTION

PRINT YOUR NAME

I, _____, the principal and/or declarant, sign my name or direct another person to sign my name to this

PRINT THE DATE

instrument this _____ day of _____ 20_____, and do hereby declare to the undersigned witness(es) that I sign it willingly, and I execute it as my free and voluntary act for the purposes herein expressed, and that I am of sound mind, and under no constraint or undue influence. I understand the full importance of this declaration.

SIGN YOUR NAME

Signed _____

PRINT YOUR CITY, COUNTY, AND STATE OF RESIDENCE

City, County, and State of Residence _____

_____

Notary

YOUR FORM MUST BE WITNESSED BY A NOTARY IN ORDER TO GRANT YOUR HEALTH-CARE REPRESENTATIVE THE ADDITIONAL POWERS OF AN ATTORNEY-IN-FACT LISTED ON PAGE 3 IN PART ONE (APPOINTMENT OF HEALTH-CARE REPRESENTATIVE)

Subscribed and acknowledged before me by _____,

the principal, this _____ day of _____, 20_____.

_____
(notary public)

My Commission expires _____

IF SOMEONE IS SIGNING THE FORM FOR YOU AT YOUR DIRECTION BECAUSE YOU ARE UNABLE TO SIGN, THE NOTARY MUST NOTE THAT HERE

I further confirm that _____, signing on behalf of

_____, the principle and/or declarant, did so at the principle and/or declarant's direction.

_____
(notary public)

PART THREE: EXECUTION (continued)

YOUR FORM MUST BE WITNESSED

Witness(es)

TWO WITNESSES ARE REQUIRED IF YOU FILLED OUT PART TWO (DECLARATION)

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years old.

Witness

ONLY ONE WITNESS — WHO MAY BE A NOTARY PUBLIC SIGNING ON THE PREVIOUS PAGE — IS REQUIRED IF YOU FILLED OUT ONLY PART ONE (APPOINTMENT OF HEALTH-CARE REPRESENTATIVE)

_____Date_____

Witness

_____Date_____

I further attest that I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care.

IF YOU CHOSE THE LIVING WILL DECLARATION IN PART TWO, YOUR TWO WITNESSES MUST ALSO SIGN HERE

Witness

_____Date_____

Witness

_____Date_____

INDIANA ORGAN DONATION FORM — PAGE 1 OF 1

ORGAN DONATION (OPTIONAL)

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your health-care representative, attorney for health care, proxy, or other agent, or your family may have the authority to make a gift of all or part of your body under Indiana law.

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

_____ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

ADD NAME OR INSTITUTION (IF ANY)

_____ Pursuant to Indiana law, I hereby give, effective on my death:

_____ Any needed organ or parts.

_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.

_____ Transplant or therapeutic purposes only.

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

Declarant name: _____

Declarant signature: _____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness _____Date_____

Address _____

_____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

Witness _____Date_____

Address _____

_____

You Have Filled Out Your Advance Directive, Now What?

1. Your Indiana Advance Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your health-care representative and successor, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.

3. Be sure to talk to your health-care representative and successor, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to change your document after it has been signed and witnessed, you should complete a new form.

6. Remember, you can always revoke your Indiana document.

7. Be aware that your Indiana document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called “non-hospital do-not-resuscitate orders,” are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

   Indiana law provides for an “Out of Hospital Do Not Resuscitate Declaration and Order.”