

MARYLAND ADVANCE DIRECTIVE AND APPOINTMENT OF HEALTH CARE AGENT

I, _____, residing at _____
(Principal) (Address)

_____, appoint the following individual as my Health Care Agent ("Agent") to make health care decisions for me: _____
(Full name of Agent)

(Address and telephone number of Agent)

2. My Agent has full power and authority to make health care decisions for me, including:

a. To 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 consent to the disclosure of this information.

b. To employ and discharge my health care providers.

c. To authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult home or other medical care facility.

d. To consent to the provision, withholding or withdrawal of any health care, including, in appropriate circumstances, life-sustaining procedures.

3. The authority of my Agent is subject to the following provisions and limitations: _____

4. If I am pregnant, my Agent shall follow these specific instructions: _____

5. My Agent's authority becomes operative: (Initial which of the two options that applies.)

[____] When my attending physician and a second physician determine that I am incapable of making an informed decision regarding my health care;

- OR -

[____] When this document is signed.

6. My Agent is to make health care decisions for me based on the health care instructions I give in this document and on my wishes as otherwise known to my Agent. If my wishes are unknown or unclear, my Agent is to make health care decisions for me in accordance with my best interest, to be determined by my Agent after considering the benefits, burdens and risks that might result from a given treatment or course of treatment, or from the withholding or withdrawal of a treatment or course of treatment.

7. My Agent shall not be liable for the costs of care based solely on this authorization.

ADDITIONAL HEALTH CARE INSTRUCTIONS

IF I AM INCAPABLE OF MAKING AN INFORMED DECISION REGARDING MY HEALTH CARE, I DIRECT MY HEALTH CARE PROVIDERS TO FOLLOW MY INSTRUCTIONS, AS SET FORTH BELOW:

Initial those statements that you want to be included. Cross through those statements that do not apply.

1. If my death from a terminal condition is imminent, and even if life-sustaining procedures are used, there is no reasonable expectation of my recovery:

[] I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

[] I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

[] I direct that if I am brain dead, an anatomical gift be offered on my behalf to a patient in need of an organ or tissue transplant. If a transplant occurs, I want artificial heart/lung support devices to be continued on my behalf only until organ or tissue suitability of the patient is confirmed and organ or tissue recovery has taken place.

2. If I am in a persistent vegetative state; that is, if I am not conscious and am not aware of my environment or ability to interact with others, and there is no reasonable expectation of my recovery:

[] I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

[] I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

[] I direct that if I am brain dead, an anatomical gift be offered on my behalf to a patient in need of an organ or tissue transplant. If a transplant occurs, I want artificial heart/lung support devices to be continued on my behalf only until organ or tissue suitability of the patient is confirmed and organ or tissue recovery has taken place.

3. If I have an end-stage condition; that is, a condition caused by injury, disease or illness, as a result of which I have suffered severe and permanent deterioration indicated by incompetency and complete physical dependency and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective:

3. (continued)

[_____] I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

[_____] I direct that my life not be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

[_____] I direct that if I am brain dead, an anatomical gift be offered on my behalf to a patient in need of an organ or tissue transplant. If a transplant occurs, I want artificial heart/lung support devices to be continued on my behalf only until organ or tissue suitability of the patient is confirmed and organ or tissue recovery has taken place.

4. [_____] I direct that no matter what my condition, medication not be given to me to relieve pain and suffering, if it would shorten my remaining life.

5. [_____] I direct that, no matter what my condition, I will be given all available medical treatment in accordance with accepted health care standards.

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

_____.

7. I direct (In the following space, indicated any other instructions regarding receipt or nonreceipt of any health care):

_____.

_____.

DESIGNATION OF ALTERNATE AGENT (OPTIONAL)

You are not required to designate an Alternate Agent but you may do so. An Alternate Agent may make the same health care decisions as your designated Health Care Agent in the event the designated Agent is unable or unwilling to act as your Agent.

If my Agent named by me shall die, become legally disabled, incapacitated or incompetent, or resign, refuse to act, or be unavailable, I name the following to act as my Agent:

Alternate Agent

Name of Alternate Agent: _____

Address and telephone number: _____

_____.

OTHER PROVISIONS

I hereby revoke any prior Maryland Advance Directive and Appointment of Health Care Agent authorization.

I understand that I may revoke this Maryland Advance Directive and Appointment of Health Care Agent authorization at any time.

It is my intent that any medical provider complying with the provisions of this Maryland Advance Directive and Appointment of Health Care Agent authorization may not be liable for following the instructions of my Agent, so long as they are consistent with my instructions.

This Maryland Advance Directive and Appointment of Health Care Agent authorization is intended to be valid in any jurisdiction in which it is presented.

Photocopies of this Maryland Advance Directive and Appointment of Health Care Agent authorization may be relied up as though they were the original.

SIGNATURE OF PRINCIPAL

I am fully informed as to all the contents of this Maryland Advance Directive and Appointment of Health Care Agent. I further declare that I am emotionally and mentally competent to make this Maryland Advance Directive and Appointment of Health Care Agent and that I understand the purpose and effect of this document.

(Signature of Principal)

(Date)

(Print Principal Name)

(Print Principal Address)

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Continued on next page.

WITNESS STATEMENT

I declare under penalty of perjury under the laws of the State of Maryland that the person who signed this document is personally known to me to be the Principal; that the Principal signed this document in my presence, or directed another person to sign this document on his behalf in his presence; that I have signed this document in the presence of the Principal and also in the presence of the other witness; that the Principal appears to be under no duress, fraud or undue influence; that I am not the Agent or Alternate Agent appointed in this document; that I am not a health care provider or an employee of the health care provider who is now, or has been in the past, responsible for the care of the person making this Appointment of Health Care Agent; and based upon my personal observation, this principal appears to be a competent individual.

(Witness No. 1 Signature)

(Witness No. 2 Signature)

(Printed Name)

(Printed Name)

(Street Address)

(Street Address)

(City, State, Zip Code)

(City, State, Zip Code)

ADDITIONAL WITNESS STATEMENT

(At least one of the two witnesses who signed above must also sign beneath the following statement.)

I declare under penalty of perjury under the laws of the State of Maryland that I am not knowingly entitled to any portion of the estate of the Principal according to the laws of intestate succession or under any will of the Principal or codicil thereto, or knowingly entitled to any financial benefit by reason of the death of the Principal.

(Witness Signature)

(Witness Signature)