

Living Will Sample Pennsylvania (aka "Advanced Medical Directive")

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ADVANCE MEDICAL DIRECTIVE AND POWER OF ATTORNEY FOR HEALTH CARE GIVEN BY JAMES ROBERT HEDGES

THIS IS AN IMPORTANT LEGAL DOCUMENT. THIS DOCUMENT DIRECTS THE MEDICAL TREATMENT YOU ARE TO RECEIVE IN THE EVENT YOU ARE UNABLE TO PARTICIPATE IN YOUR OWN MEDICAL DECISIONS AND YOU ARE EITHER IN A TERMINALLY ILL CONDITION OR PERSISTENTLY UNCONSCIOUS. THIS DOCUMENT CAN CONTROL WHETHER YOU LIVE OR DIE. PREPARE THIS DOCUMENT CAREFULLY AND READ IT COMPLETELY. PLEASE REVIEW IT PERIODICALLY.

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as "surrogate" or, as used in this form, agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. Your agent may not be an owner, operator, or employee of a residential long-term health-care institution at which you are receiving care.

Under this agreement, your agent must follow the directions you give in Part 2 hereof regarding which types of health care treatment are to be withdrawn or withheld under the circumstances stated.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

* * * * *

**PART 1
POWER OF ATTORNEY FOR HEALTH CARE**

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me: **Sara Jane Hedges** whose residence is 1212 Holiday Drive, Louisville, KY.

(2) AGENT'S AUTHORITY: My agent is authorized to make all health-care decisions for me, including those forms of health care necessary to keep me alive. Furthermore, the authority I give my agent shall include decisions to provide, withhold, or withdraw artificial nutrition. The power of my agent granted herein shall not be affected by my subsequent incapacity.

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when both (1) my attending physician determines that I am no longer able to understand, appreciate, and direct my medical treatment **and** (2) two physicians—one of whom is my attending physician and the other is qualified and experienced in making such diagnosis—have personally examined me and have diagnosed and documented in my medical records that I am either terminally ill **or** that I am in a state of persistent unconsciousness with no reasonable expectation of recovery.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care and any instructions I give in Part 2 of this form. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

I have the primary right to make my own decisions concerning treatment that might unduly prolong the dying process. By this declaration, I express to my physician, family and friends my intent.

(6) END-OF-LIFE DECISIONS: In cases where both (1) my attending physician determines that I am no longer able to understand, appreciate, and direct my medical treatment **and** (2) two physicians—one of whom is my attending physician and the other is qualified and experienced in making such diagnosis—have personally examined me and have diagnosed and document in my medical records that I am either terminally ill or that I am in a state of persistent unconsciousness with no reasonable expectation of recovery, I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choices I have stated below. The word "Withhold" shall be used to mean both withholding the treatment if it has not yet been given and withdrawing the treatment if it is currently being administered.

* Artificially supplied nutrition and hydration (including tube feeding or food and water)	Withhold
* Surgery or other invasive procedures (i.e., those where medical instruments must enter the body)	Withhold
* Heart-lung resuscitation (CPR)	Withhold
* Antibiotics	Do NOT Withhold
* Kidney or Renal dialysis	Withhold
* Mechanical ventilator (respirator)	Withhold
* Chemotherapy and other radiation therapy	Withhold
* All other "life sustaining" medical procedures that are merely intended to keep me alive without reasonable hope of improving my condition	Withhold

I hereby acknowledge the above choices:

JAMES ROBERT HEDGES

Declarant / Principal

(7) RELIEF FROM PAIN: I direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be

habit-forming.

(8) HIPAA Privacy Authorization. I hereby authorize my Agent to execute any form authorization for use or disclosure of my Protected Health Information relating to past, present or future medical records required by the Health Insurance Portability and Accountability Act ("HIPAA"). My Agent is authorized to execute a HIPAA form authorization for release of my medical records in favor of any health provider or other party that the Agent deems appropriate.

**PART 3
DONATION OF ORGANS AT DEATH
(OPTIONAL)**

(10) ORGAN DONATION: Upon my death, I wish to donate any and all of my organs, tissues, or other bodily parts for use in transplant to another human being. I authorize my health care agent to give consent to the medical organization of his choosing for donation of my aforementioned body parts.

**PART 4
PRIMARY PHYSICIAN
(OPTIONAL)**

(11) DESIGNATION OF PHYSICIAN: I designate the following physician as my primary physician: John Paul Jones, MD.

* * * * *

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

(13) DURABILITY OF HEALTH CARE AGENT'S POWERS: This Health Care Power of Attorney is a durable power of attorney and the authority of my agent shall not terminate if I become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive. If I have also executed a durable financial power of attorney, this document is not meant to override that document. My health care agent's powers only extend to health care decisions as outlined in this document.

(14) DEFINITIONS:

"Artificially Provided Nutrition and Hydration" means feeding a patient through a means that is not natural such as (1) intravenously (i.e., inserting a needle directly into a patient's veins through which food or water would be forced into the patient's blood stream) or (2) a feeding tube inserted in the nose or mouth through which food or water would be forced into an individual's stomach. Assisted feeding, such as by a spoon or bottle, where the patient actively participates in the feeding process by chewing or swallowing is not considered "artificially provided nutrition and hydration".

"Persistently Unconscious" means a condition that, to a reasonable degree of medical certainty: (a) will last permanently without improvement, (b) one in which cognitive thought, purposeful

action, and awareness of self and environment are absent, and (c) which has existed for a period of time sufficient, in accordance with applicable medical standards, to make a diagnosis called for in parts (a) and (b) hereof.

"Terminally Ill" means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, to a reasonable degree of medical certainty, result in death within a relatively short time.

"Life-Sustaining Treatment" means any medical treatment, procedure, or intervention that, in the judgment of the attending physician, when applied to the patient, would serve only to prolong the dying process where the patient has a terminal illness or injury, or would serve only to maintain the patient in a condition of permanent unconsciousness. These procedures shall include, but are not limited to, surgery, chemotherapy, CPR, dialysis, use of mechanical respirators, blood transfusions, and the administration of all drugs and antibiotics (except those intended to ease pain).

IN WITNESS WHEREOF, I sign the foregoing as my Health Care Directive and Medical Power of Attorney, do it willingly and as my free and voluntary act for the purposes herein expressed, and further state that I am eighteen years of age or older, of sound mind, and under no constraint or undue influence, this ____ day of March, 2007.

_____ (Please also sign on page 3 above.)

JAMES ROBERT HEDGES

Declarant / Principal

City and State of Residence: Springfield, Error: Error: expected [/HIDEIF], but found [/showif] instead[/showif]Pennsylvania

Social Security Number: _____

Each of us declares under penalty of perjury under the laws of the State of Pennsylvania that the following is true and correct: The Declarant signed this document in our presence, all of us being present at the same time; We now, at the Declarant's request, and in the Declarant's and each other's presence, sign below as witnesses; We believe the Declarant is of sound mind and memory; We believe that this document was not procured by duress, menace, fraud or undue influence; neither of us is a health care provider for Declarant, neither of us is an employee of a health care provider for Declarant; neither of us is the operator or employee of a community or long-term care facility; neither of us is a patient in a health care facility in which declarant is a patient; neither of us (at this time) has a claim against Declarant's estate; neither of us has a financial responsibility for Declarant's medical care; and neither of us is related by blood, marriage, or adoption to Declarant.

Signature of Witness #1
Print Name:
Address:

Signature of Witness #2
Print Name:
Address:

STATE OF PENNSYLVANIA)
) SS.
COUNTY OF _____)

I, the undersigned, a Notary Public authorized to administer oaths in the State of Pennsylvania, certify that JAMES ROBERT HEDGES, the Declarant and the witnesses whose names are signed to the attached instrument, having appeared together before me and having been first duly sworn, each then declared to me that the Declarant had willingly signed and executed the instrument as his or her Medical Directive and Medical Power of Attorney, and that he / she executed such instrument as his or her free and voluntary act for the purposes therein expressed; and that each of the witnesses, in the presence and hearing of the Declarant, signed the document as witness and that to the best of his or her knowledge the Declarant was at that time eighteen (18) or more years of age, of sound mind, and under no constraint or undue influence.

IN WITNESS WHEREOF, I have hereunto subscribed my name and affixed my official seal this ____ day of March, 2007.

_____ My Commission Expires: _____
Notary Public

(Note: This page is **not** to be attached to your Health Care Directive.)

INSTRUCTIONS REGARDING EXECUTION OF YOUR HEALTH CARE DIRECTIVE AND MEDICAL POWER OF ATTORNEY

- A. Please remember to fill in your social security number below your name on the signature page.
- B. **Please note that the principal's signature is required on pages 3 and 5 of this document.**
- C. We recommend that you execute two originals of your Health Care Directive. Give the first original to the Health Care Agent you named and you retain the second original in your home in place known to family members. If you currently under medical care for a serious medical condition, we also suggest you execute a third original and give it to your primary physician.
- D. **Witnesses.** We have written this health care directive to be valid in all 49 states (and the District of Columbia) whose laws allow for this type of document. There are varying rules among the states regarding what types of persons cannot witness a health care directive. As such, we have included with our form all the prohibitions against witness from the across the country making the list somewhat length. The following persons cannot act as a witness to a health care directive:
1. A health care provider for Declarant,
 2. An employee of a health care provider for Declarant,
 3. The operator or employee of a community or long-term care facility,
 4. Patient in a health care facility in which declarant is a patient,
 5. Individual with a claim against Declarant's estate,
 6. Individual who has a financial responsibility for Declarant's medical care, and
 7. Individual related by blood, marriage, or adoption to Declarant.
- Also, the health care agent should not be one of the witnesses to this document.** The two witnesses need to be physically present when you sign the health care directive and attest to the fact that they saw you sign the document. If you have the document notarized, the witnesses will need to be with you in front of the notary.
- E. Where do I get a notary? Your local bank is the best place to find a notary. If you cannot find a notary at your bank, please consult your local Yellow Pages which has them listed under "notaries public".
- F. Notice: This form is not intended for use in the State of Wisconsin.
- G. What if I decide to make changes to my document? We will keep your responses to the online questionnaire in our database **for 60 days after the date of purchase**. During this time, you may go to the User Administration section of our site to call up your form questionnaire and make changes—the URL is <https://www.medlawplus.com/user/>. You shall need your "user name" and "password" to re-enter the system. Once in the User Administration area, click on the text link to your form questionnaire which is located on the upper-left of the page. Make the desired changes to your responses in the questionnaire and submit to create a revised document. If you have problems calling up your old data, email us at administrator@medlawplus.com. We do our best to give a prompt response to all inquiries, usually within a few hours. NOTE: Upon registration, our system emailed to you our record of your "user name" and "password".

DISCLAIMER

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