

**ADVANCE DIRECTIVES OF \_\_\_\_\_**

To Any Physician Who Is Treating Me, this document contains the following:

1. My Living Will or Health Care Instructions
2. My Appointment of A Health Care Agent
3. My Appointment of An Attorney-in-Fact For Health Care Decisions
4. The Designation of My Conservator Of The Person For My Future Incapacity
5. My Document of Anatomical Gift

As my physician, you may rely on any information provided by my health care agent and decisions made by my attorney-in-fact for health care decisions or conservator of my person, if I am unable to make a decision for myself.

**LIVING WILL or HEALTH CARE INSTRUCTIONS**

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a testament of my wishes.

I, \_\_\_\_\_, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

*Specific Instructions*

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

	<u>Provide</u>	<u>Withhold</u>
Cardiopulmonary Resuscitation	_____	_____
Artificial Respiration (including a respirator)	_____	_____
Artificial means of providing nutrition and hydration	_____	_____
_____	_____	_____
_____	_____	_____

Other specific requests:

\_\_\_\_\_

I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

**APPOINTMENT OF HEALTH CARE AGENT AND  
ATTORNEY-IN-FACT FOR HEALTH CARE DECISIONS**

I appoint \_\_\_\_\_ to be my health care agent and my attorney-in-fact for health care decisions. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, \_\_\_\_\_ is authorized;

*As My Health Care Agent to:*

1. Convey to my physician my wishes concerning the withholding or removal of life support systems;
2. Take whatever actions are necessary to ensure that any wishes are given effect;

*As My Attorney-In-Fact to:*

1. Act in my name, place and stead in any way which I myself could do, if I were personally present, with respect to health care decisions as defined in the Connecticut Statutory Short Form Power of Attorney Act to the extent that I am permitted by law to act through an agent;
2. Consent, refuse or withdraw consent to any medical treatment other than that designed solely for the purpose of maintaining physical comfort, withdrawal of life support systems, or withdrawal of nutrition or hydration.

If \_\_\_\_\_ is unwilling or unable to serve as my health care agent and my attorney-in-fact for health care decisions, I appoint \_\_\_\_\_ to be my alternative health care agent and my attorney-in-fact for health care decisions.

I further instruct that upon being informed that my attending physician has determined that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, my attorney-in-fact to execute an affidavit stating said determination has occurred.

**DOCUMENT OF ANATOMICAL GIFT**

I make no anatomical gift at this time. \_\_\_\_\_ (Initial here)

I hereby make this anatomical gift, \_\_\_\_\_ (Initial here)  
if medically acceptable, to take effect upon my death

I give: (check one)

\_\_\_\_ (1) any needed organs or parts

\_\_\_\_ (2) only the following organs or parts:

\_\_\_\_\_  
\_\_\_\_\_

to be donated for: (check one)

\_\_\_\_ (1) any of the purposes stated in subsection (a) of section 19a-279f of the general statutes

\_\_\_\_ (2) these limited purposes \_\_\_\_\_.

**DESIGNATION OF A CONSERVATOR OF THE PERSON**

If a conservator of my person should need to be appointed, I designate \_\_\_\_\_, be appointed my conservator. If \_\_\_\_\_ is unwilling or unable to serve as my conservator, I designate \_\_\_\_\_. No bond shall be required of either of them in any jurisdiction.

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

Date \_\_\_\_\_, 200\_\_\_\_ x\_\_\_\_\_ L.S.

STATE OF CONNECTICUT )  
: ss. \_\_\_\_\_  
COUNTY OF \_\_\_\_\_ ) (Town)

Personally appeared \_\_\_\_\_, signer of the foregoing instrument, and acknowledged the same to be his/her free act and deed, before me, this \_\_\_\_ day of \_\_\_\_\_, 200\_\_.

\_\_\_\_\_  
Commissioner of the Superior Court  
Notary Public  
My Commission expires: \_\_\_\_\_

**WITNESSES' STATEMENTS**

This document was signed in our presence by \_\_\_\_\_ the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

x\_\_\_\_\_  
(Witness)  
\_\_\_\_\_  
(Number and Street)  
\_\_\_\_\_  
(City, State and Zip Code)

x\_\_\_\_\_  
(Witness)  
\_\_\_\_\_  
(Number and Street)  
\_\_\_\_\_  
(City, State and Zip Code)

**(NOTE: This Form is Optional)**

**WITNESSES' AFFIDAVITS**

STATE OF CONNECTICUT )  
 :  
 COUNTY OF \_\_\_\_\_ ) ss. \_\_\_\_\_  
 (Town)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointments of a health care agent and an attorney-in-fact, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_.

x \_\_\_\_\_  
(Witness)  
\_\_\_\_\_  
(Number and Street)  
\_\_\_\_\_  
(City, State and Zip Code)

x \_\_\_\_\_  
(Witness)  
\_\_\_\_\_  
(Number and Street)  
\_\_\_\_\_  
(City, State and Zip Code)

Subscribed and sworn to before me, by \_\_\_\_\_ and \_\_\_\_\_ the signing witnesses to the foregoing affidavit, on this \_\_\_\_\_ day of \_\_\_\_\_,

\_\_\_\_\_  
Commissioner of the Superior Court  
Notary Public  
My Commission expires: \_\_\_\_\_

(Print or type name of all persons signing under all signatures)