MEMORIAL HOSPITAL
And Health Care Center

Patient Label if Applicable

Indiana Healthcare Representative:
A Healthcare Representative is a person chosen by you to make healthcare decisions, including end-of-life decisions, if you are unable to make your own. It is a good idea to talk with this person about your preferences ahead of time. A doctor will determine if you are unable to make your own decisions.

My name (Full Legal Name – also known as "declarant") Date of Birth (MM/DD/YYYY)

_____ _____

My Healthcare Representative can make decisions for me if I cannot make and share my own healthcare decisions. My Healthcare Representative must follow my wishes and values. My values include my ideas about dignity and quality of life. If my Healthcare Representative does not know my wishes, my Healthcare Representative must act in good faith and make decisions in my best interest. These decisions include but are not limited to:

- Agreeing to medical treatment
- Stopping medical treatment
- Refusing medical treatment
- Arranging comfort care

I want the following person to be my Healthcare Representative (HCR):

HCR Name Relationship HCR Phone Number

_____ _____ _____

If my primary HCR named above is not able or available to act for me, I want the following person to be my backup Healthcare Representative:

Backup HCR Name Relationship Backup HCR Phone Number

_____ _____ _____

OPTIONAL STATEMENT OF END-OF-LIFE PREFERENCES:
I would like to provide some additional guidance for my Healthcare Representative on my end-of-life preferences. (Please select only one option below).

_____ If I am unable to make my own decisions and my attending physician believes that I will not recover, medical treatment may be forgone or withdrawn if they do not offer reasonable hope of benefit to me or are excessively burdensome. I would want continued medical care to make me comfortable and to relieve my pain.

_____ It is more important to me, no matter how sick I am or how unlikely my chances for recovery are, for my life to be prolonged to the greatest extent possible, in accordance with reasonable medical standards.

_____ I choose to **NOT** complete this section at this time.

Declarant Name: _____

REQUIRED SIGNATURES:
By signing this form, I cancel and revoke every Healthcare Power of Attorney I signed in the past.

_____ _____
Signature (Declarant) Date

_____

Printed Name (Declarant)

This form must be either signed by 2 adult witnesses (below left) or notarized (below right) to be legally valid.

SIGNATURE OF 2 ADULT WITNESSES

Each of the undersigned Witnesses confirms that he or she has received satisfactory proof of the identity of the Declarant and is satisfied that the Declarant is of sound mind and has the capacity to sign the above Advance Directive. **At least one of the undersigned Witnesses is not a spouse or other relative of the Declarant.**

_____
Signature of Adult Witness 1

_____
Printed Name of Adult Witness 1

_____
Date

_____
Signature of Adult Witness 2

_____
Printed Name of Adult Witness 2

_____
Date

_____ Initial here if the Witnesses participated by phone.

NOTARIZATION

STATE OF INDIANA)

COUNTY OF _____)

Before me, a Notary Public, personally appeared

_____

(name of signing Declarant), who acknowledged the execution of the foregoing Advance Directive as his or her voluntary act, and who, having been duly sworn, stated that any representations therein are true.

Witnesses my hand and Notarial Seal on this

_____day of _____, 20___

_____
Signature of Notary Public

_____
Notary's Printed Name (if not on seal)

_____
Commission Number (if not on seal)

_____
Commission Expires (if not on seal)

_____
Notary's County of Residence