ADVANCE DIRECTIVE
for Health Care Decisions

I, _____ [*insert name*] am an adult resident of _____ County, Indiana. I currently have the capacity to make my own decisions about my health care.

If this Advance Directive does not specifically address a specific issue, then I intend that the rules and principles in I.C. 16-36-7 will apply and control, but in a manner consistent with my known wishes and preferences. If this Advance Directive is silent on an issue and if my wishes and preferences cannot be reliably determined, I intend that my Health Care Representative and health care providers act in a manner consistent with my best interests.

Effective Immediately

This Advance Directive and my Health Care Representative(s)' power and authority under it are effective immediately and will remain in effect even if I later become incapacitated, disabled, or incompetent.

My Health Care Representative(s)

I appoint the following person(s) as my Health Care Representative(s) in decreasing order of priority, but subject to the conditions stated in the next section ("My Continuing Right to Act and Decide Personally") below.

Priority	Name of Representative and Telephone Number(s)	Mailing Address and e-mail address (if any)
First		
Second		

At all times, my Health Care Representative who has the highest priority and who is reasonably available to act has the full authority to make and communicate health care decisions and give informed consent on my behalf, but subject to my right to act personally.

My Continuing Right to Act and Decide Personally

Although I have made this Advance Directive effective immediately upon signing, I have the right and the power to act personally to make my own health care decisions, to issue my own instructions and consents to health care providers. All health care providers must first communicate with me, unless a licensed health care provider who has treated or examined me has concluded in writing that I am not able to personally give informed consent to treatment or to make my own health care decisions. Until I have been determined to be incapacitated under the preceding sentence, I have the right to overrule, block or veto any health care decision that any Health Care Representative (named above) makes or attempts to make for me.

Decision-Making Standards for My Health Care Representative(s)

Whenever a Health Care Representative named above makes health care decisions or issues instructions or consents on my behalf, I expect my Health Care Representative to act in good faith and in my best interests, on the basis of what my Health Care Representative believes I would decide to do if I were capable of making decisions and giving consents myself and if I had all the pertinent information available to my Health Care Representative.

My Wishes and Preferences About Life-Prolonging Procedures [*illustrative sample only*]

If I am competent to give my own consents and instructions for my health care, my orally-stated instructions will always supersede and control over the instructions I have stated below.

I authorize my Health Care Representative to make decisions in my best interests concerning withdrawal or withholding of health care. If, at any time and 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 to me or that such health care would be excessively burdensome, then my Health Care Representative may express my will 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 and other relevant health care givers. In his or her best judgment about what is appropriate, my Health Care Representative may (but is not required to) discuss any decision under this paragraph with members of my family who are available.

If my treating physician or other licensed health care provider has determined with reasonable certainty that I am terminally ill or in a persistent and irreversible coma:

- If I have no pulse and if am not breathing, do not attempt resuscitation (DNR).
- Maximize my comfort through symptom management and relieve my pain and suffering through available measures, including the administration of medication to me through any route.
- Do not provide artificial nutrition or hydration (tube feeding) to me, except for the provision of fluids to the extent necessary to deliver pain medication.
- Do not transfer me from my current location to a hospital for life-sustaining treatment unless my comfort needs cannot be satisfied in my current location.

Signature

You may direct another adult (who is not one of your named Health Care Representatives, and not the Notary Public or one of the witnesses) to make your signature for you in your presence. See IC § 16-36-7-19 for a definition and explanation of the "presence" requirement.

Your signature must be made in the "presence" of a Notary Public OR in the "presence" of two adult witnesses. Either the countersigning by two witnesses OR notarization is sufficient; both are not required. If you use two witnesses, at least one witness cannot be your spouse or another relative.

Please initial one space below to confirm the signing method used:

Signed on paper in direct presence of witnesses or notary public _____	Signed electronically with 2-way audio-visual interaction with witnesses _____	Signed by Declarant and witnesses or notary in 2 or more paper counterparts _____	Signed by Declarant and witnesses or notary with telephonic interaction _____

Signed on this _____ day of _____ 20_____.

_____
Signature of Declarant (signer)

_____
Printed name of adult (if any) who signs for Declarant

_____
Printed name of Declarant

Complete ONE of the two following blocks

Signatures of 2 Adult Witnesses

_____
Signature of Adult Witness 1

_____
Printed Name of Adult Witness 1

_____
Signature of Adult Witness 2

_____
Printed Name of Adult Witness 2

Notarization

STATE OF INDIANA)
) SS:
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.

Witness 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