If your healthcare providers state you will never regain these functions, you are to be provided care that will keep you comfortable and pain free until you die.

In order to live the life you desire, it is important for you to retain the ability to: (INITIAL ALL THAT APPLY TO YOU)

- Share your thoughts through words, gestures, or assistive devices.
- Understand what people are saying to you.
- Know that you are hungry. You are able to eat and swallow if someone feeds you.
- Chew and swallow food. Losing this ability results in the need of a feeding tube.
- Take care of your own toileting needs.
- Take a bath or shower with or without assistance.
- Interact in social settings.

List other functions that are important to you:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
Remember we discussed that it’s best to name one person, not a committee. There are plenty of reasons that this person might not be your child or your spouse but at the same time, it is your choice.

+ The person I choose to speak for me if and when I cannot speak for myself.

1. __________________________________________________________________________

+ If the first person I named is not available, this person will step in.

2. __________________________________________________________________________

Please turn to page 213 and add your proxy choices to line one and two. Fill in the rest of the form and before you sign, find a couple of neighbors or friends to witness for you.
Based upon the work you see I have done on the preceding pages, I want you to know that if and when I can no longer speak for myself, ______________________________________________________________________

Address: ______________________________________________________________________

City/State: __________________________ Phone No: __________________________

will be in charge of making sure that my wishes are respected. If this person is not available, the alternate proxy/surrogate is ______________________________________________________________________

Address: ______________________________________________________________________

City/State: __________________________ Phone No: __________________________

I, ________________________________ being of sound mind, do hereby designate the above to serve as my Attorney-in-Fact, for the purpose of making medical treatment decisions for me (including the withholding or withdrawal of life-sustaining procedures, nutrition, hydration) should I be diagnosed and certified as having an irreversible condition and be comatose, incompetent, or otherwise mentally or physically unable to make such decisions for myself.
My named proxies are strong people who know me well and need only to refer to my answers to the questions in this plan which I have written in my own hand or have dictated to a caregiver.

The key information my proxy needs comes from the sections of these pages that bear this sign: + My answers to these questions constitute my advance directive in case I do not take the time to create a separate document.

I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

My Name (In Print): __________________________________________________

My Signature: __________________________ Date: __________

Address: __________________________________________________________

In our joint presence, __________________________ who is of sound mind and eighteen (18) years of age, or older, voluntarily dated and signed this writing or directed it to be dated and signed for the grantor.

Witness 1 Name: _________________________________________________

Address: _________________________________________________________

Witness Signature: __________________________ Date: __________

Witness 2 Name: _________________________________________________

Address: _________________________________________________________

Witness Signature: __________________________ Date: __________