Advance Directive

1. Designation of Health Care Surrogate

I, _____ #_____ designate _____

(Grantor Name & Number) (Name of surrogate)

as my health care surrogate to make health care decisions for me in accordance with this directive when I no longer have decisional capacity.

If _____ refuses or is not able to act for me,

(Name of surrogate)

I, _____ #_____ designate _____

(Grantor Name & Number) (Name of alternate surrogate) as my health care surrogate.

Any prior designation is revoked.

2. Living Will Directive

My wishes regarding life-prolonging treatment and artificially provided nutrition and hydration to be provided to me if I no longer have decisional capacity, have a terminal condition, or become permanently unconscious have been indicated by checking and initialing the appropriate lines below. If I do not designate a surrogate, the following are my directions to my attending physician. If I have designated a surrogate, my surrogate shall comply with my wishes as indicated below:

_____ Direct that treatment be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain.

_____ DO NOT authorize that life-prolonging treatment be withheld or withdrawn.

_____ Authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

_____ DO NOT authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

_____ Authorize my surrogate designated above, to withhold or withdraw artificially provided nourishment or fluids, or other treatment if the surrogate determines that withholding or withdrawing is in my best interest; but I do not mandate that withholding or withdrawing.

3. Anatomical Gift

_____ Authorize the giving of all or any of my body upon death for any purpose specified in KRS 311.185.

_____ DO NOT authorize the giving of all or any part of my body upon my death.

Other Directions:

_____

_____

_____

_____

In the absence of my ability to give directions regarding the use of life-prolonging treatment and artificially provided nutrition and hydration, it is my intention that this directive shall be honored by my attending physician, my family, and any surrogate designated pursuant to this directive as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of the refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.

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

Signed this _____day of _____, 20_____.

(Date) (Month) (Year)

Printed name & number of grantor:_____ #_____

Signature of grantor: _____

Address of grantor: _____

_____

Witnessing Procedure

In our joint presence, the grantor, _____ #_____ who is of sound mind

(Grantor Name & Number)

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.

Signature of Witness: _____

Address of Witness: _____

_____

Signature of Witness: _____

Address of Witness: _____

_____

-OR-

STATE OF KENTUCKY

_____COUNTY

Before me, the undersigned authority, came the grantor who is of sound mind and eighteen (18) years of age or older, and acknowledged that he voluntarily dated and signed this writing or directed it to be dated and signed as above.

Done this _____ day of _____, 20_____.

_____

(Signature of notary public or other person authorized to administer oaths)

Date commission expires: _____

Execution of this document restricts withholding and withdrawing of some medical procedures. Consult Kentucky Revised Statutes or your attorney.