Living Will

This document contains two parts which you can fill in with your preferred directive. First is the Health Care Directive or coined as the living will. This form enables you to disclose your preferences regarding the end-of-life medical treatment and care that you need from your health care providers. The other one is the Health Care Power of Attorney. In contrast with the preceding form, the second form allows you to appoint a particular person to decide on your behalf adhering to your wishes. You sign what favors you and what best fits your needs.

Declaration of this will is made this _____.

(Kindly input “x” on the spaces provided pertaining that you do not wish to fill out any of this form.)

HEALTH CARE DIRECTIVE (LIVING WILL)

I, _____, currently residing in _____, wishes to charge my health care providers of my preferences for health care under the requirements outlined in the _____, in the instance that I fall seriously ill which may cause my inability to communicate. I included the last four (4) digits of my social security number (SSN) being _____ herein.

A. LIFE SUPPORT

I desire that all my health care providers take much effort in unison, in keeping me well using the available medical treatments and therapies. If my quality of life is in incurable condition at any time and my attending physicians admit that my death is imminent,

whether or not these life-sustaining treatments and procedures are used, I direct that all treatments extending my life will be withheld from me.

An incurable condition or an unacceptable quality of life means either of the following.

o In Chronic coma, in continuous absence of responsiveness and awareness or a vegetative state.

o Unable to communicate for needs

o Unable to recognize family names and members

o In absolute need for daily care and assistance

o Others

Kindly choose one.

____ Despite having any of the instances stated above, I still desire to receive continued treatment with primary needs such as food and water by tube.

____ If at any time, I end up with the mentioned life state, I do not wish to continue whatever treatment I have even treated with food and water by tube.

B. LIFE-SUSTAINING TREATMENT

I wish that my physicians continue to provide me with specific life-sustaining treatments such as the following:

o Cardiopulmonary Resuscitation (CPR)

o Surgery

o Dialysis

o Ventilation

o Feeding Tube

C. END OF LIFE DESIRES

The imminence of my death shall concern the following:

HEALTH CARE POWER OF ATTORNEY

I, _____ designate _____ as my Agent to take account of all my health care concerns and decision making, covering both my physical and mental health. This power of attorney given to the Agent with an address of _____, and _____, as the contact information, take effect when I am no longer capable in reaching out my health care needs and wishes. The Agent's responsibilities comprise but are not limited to the power or the right to give in or withhold consent for possible surgical and medical assistance, hospitalizations, and others that are reliant on my health care needs. When there is uncertainty about my forthcoming, my Agent's decisions are binding toward my heirs, devisees, and personal representatives.

I also release the authority of my Agent to access and receive all my health records and information outlined and governed by the Health Insurance Portability, and Accountability Act of 1996 (HIPAA) stated in 45 CFR Part 160 and Subparts A and E of Part 164 or in short, the HIPAA Privacy Rule.

In a probable instance where the Agent refuses the power, I hereby appoint _____, as my successor agent, addressing all the mentioned responsibilities above. The successor agent has _____, as contact information, and _____, as the permanent address.

Declaration of this will's validity is under my affixed signature over my printed name on _____.

Signature: _____

Principal: _____

WITNESS ACKNOWLEDGMENT FORM

I, _____, hereby declare that the _____, as the principal participant of this living will is in his or her sound mind upon writing and executing this document. With an address of _____, _____, I ensure that I am free from having consanguineal origin toward the Principal. I am not the Agent or the successor mentioned in this living will. Within reach of my knowledge, I don't benefit from his or her will nor claim against his or her real estate. I have no direct involvement in the Principal's health care as well.

_____ _____

WITNESS SIGNATURE DATE OF SIGNING