

MY HEALTH CARE INSTRUCTIONS

THESE ARE MY HEALTH CARE INSTRUCTIONS. MY APPOINTMENT OF A HEALTH CARE AGENT, MY APPOINTMENT OF AN ATTORNEY-IN-FACT FOR HEALTH CARE DECISIONS, THE DESIGNATION OF MY CONSERVATOR OF THE PERSON AND/OR ESTATE FOR MY FUTURE INCAPACITY AND MY DOCUMENT OF ANATOMICAL GIFT.

To any physician who is treating me: These are my health care instructions including those concerning the withholding or withdrawal of life support systems, together with the appointment of my health care agent and my attorney-in-fact for health care decisions, the designation of my conservator of the person and/or estate for future incapacity and my document of anatomical gift. As my physician, you may rely on any decision made by my health care agent, attorney-in-fact for health care decisions or conservator of my person and/or estate, if I am unable to make a decision for myself.

I, _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment. The life support systems which I do not want include, but are not limited to: artificial respiration, cardiopulmonary resuscitation and artificial means of providing nutrition and hydration. I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

I appoint my _____, [RELATIONSHIP]_____, [NAME] to be my health care agent and my attorney-in-fact for health care decisions. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, my health care agent and attorney-in-fact for health care decisions is authorized to:

1. Convey to my physician my wishes concerning the withholding or removal of life support systems;
2. Take whatever actions are necessary to ensure that any wishes are given effect;
3. Consent, refuse or withdraw consent to any medical treatment as long as such action is consistent with my wishes concerning the withholding or removal of life support systems; and
4. Consent to any medical treatment designed solely for the purpose of maintaining physical comfort.

I my _____, [RELATIONSHIP]_____, [NAME] is unwilling or unable to serve as my health care agent and my attorney-in-fact for health care decisions, I appoint my _____ [RELATIONSHIP], _____ [NAME], to be my alternative health care agent and my attorney-in-fact for health care decisions.

If a conservator of my person and/or estate should need to be appointed, I designate my _____ [RELATIONSHIP], _____ [NAME], to be appointed my Conservator.

If my _____ [RELATIONSHIP}, _____ [NAME], is unable or unwilling to serve as my Conservator, I designate my _____ [RELATIONSHIP], _____ [NAME], as my Conservator. No bond shall be required of either of them in any jurisdiction.

I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. I give: (check one)

- 1. any needed organs or parts
2. only the following organs or parts: _____

_____.

To be donated for: (check one)

- 1. any of the purposes stated in subsection (a) of section 19a-279f of the general statutes
2. these limited purposes: _____.

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

Dated: _____

This document was signed in our presence by _____, the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

(Witness)

(Witness)

(Number and Street)

(Number and Street)

(City, State and Zip Code)

(City, State and Zip Code)

STATE OF CONNECTICUT)
) ss.
COUNTY OF LITCHFIELD)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointments of a health care agent and an attorney-in-fact, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request, and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20____.

(Witness)

(Witness)

Subscribed and sworn to before me this _____ day of _____, 20____.

Notary Public
My Commission Expires: