

The following is the Advance Directive for Healthcare statutory form:

Declaration

I, _____, being of sound mind, willingly and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment:

- I ☐ do ☐ do not want cardiac resuscitation.
- I ☐ do ☐ do not want mechanical respiration.
- I ☐ do ☐ do not want tube feeding or any other artificial or invasive form of nutrition (food).
- I ☐ do ☐ do not want tube feeding or any other artificial or invasive form of hydration (water).
- I ☐ do ☐ do not want blood or blood products.
- I ☐ do ☐ do not want any form of surgery or invasive diagnostic tests.
- I ☐ do ☐ do not want kidney dialysis.
- I ☐ do ☐ do not want antibiotics.

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

Other Instructions

- I ☐ do ☐ do not want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and in a terminal condition or in a state of permanent unconsciousness.

Name and address of surrogate (if applicable)

Name and address of substitute surrogate (if surrogate designated above is unable to serve)

continued on reverse side

Statutory Form of

Declaration



Thomas Jefferson University Hospitals
 Jefferson Health System

Thomas Jefferson University Hospital —
Center City

Ford Road

Methodist Hospital Division

Jefferson Hospital for Neuroscience

continued from inside

I ☐ do ☐ do not want to make an anatomical gift of all or part of my body, subject to the following limitations (if any).

I made this declaration on the _____ day of _____ month, 20_____

Declarant: _____

Signature: _____

Address: _____

The declarant, or the person on behalf of and at the direction of the declarant, knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness: _____

Signature: _____

Address: _____

Witness: _____

Signature: _____

Address: _____