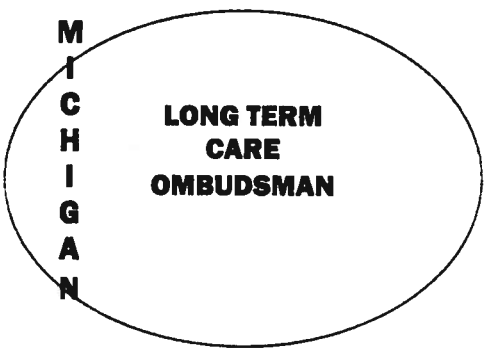
Advance Directives

Planning for Medical Care in the Event of Loss of Decision-Making Ability



Sarah Slocum Priscilla Cheever Bradley Geller
Michigan State Long Term Care
Ombudsman Program
1-866-485-9393

Advance Directives

Planning for Medical Care in the Event of Loss of Decision-Making Ability

- Durable Power of Attorney for Health Care
- Living Will
- Do-Not-Resuscitate Declaration
- Declaration of Anatomical Gift

Foreword

We all value the right to make decisions for ourselves. Whether we term this autonomy, liberty or independence, it is central to our concept of dignity.

One important area in which we exercise independence is in choosing the medical treatment we receive. Few would deny a competent adult has the right to consent to or refuse particular medical treatments or medically related services.

Unfortunately, due to illness or injury, we may not remain able to participate in treatment decisions. Such disability may be temporary or permanent.

No one likes to consider the possibility of becoming unable to make decisions. It is easy to put off thinking about that happening, and what treatment we would like in those circumstances.

As difficult as it is to confront these issues, by doing so we can help ensure our wishes are honored in the future.

Once you determine your wishes, the process of planning is relatively simple and inexpensive or free. This pamphlet contains information on advance directives to assist you. The fill-in-the-blanks forms at the end of the pamphlet are but one option should you choose to proceed.

Questions and Answers About Advance Directives

A. Introduction

What is an *advance directive*?

An advance directive is a written document in which you specify what type of medical care you want in the future, or who you want to make decisions for you, should you lose the ability to make decisions for yourself.

Why is there a need for advance directives?

Years ago, most individuals died in their own homes. Today, there is greater chance of dying in a hospital or nursing home.

Expanding technology has increased the treatment choices we face, and improved public health has increased life expectancy. Decisions may have to be made concerning our care at a time we can no longer communicate our wishes.

What are the advantages of having an advance directive?

We each have our own values, wishes and goals. Having an advance directive provides you some assurance your personal wishes concerning medical and mental treatment will be honored at a time when you are not able to express them. Having an advance directive may also prevent the need for a guardianship imposed through the probate court.

Must I have an advance directive?

No. The decision to have an advance directive is purely voluntary. No family member, hospital or insurance company can force you to have one, or dictate what the document should say if you decide to write one. A hospital or nursing home or hospice organization cannot deny you service because you do or don't have an advance directive.

Are there different types of advance directives?

Yes. Three types are a durable power of attorney for health care, a living will, and a do-not-resuscitate declaration.

There is also a declaration of anatomical gift, to take effect when you die.

Can I have more than one type of advance directive?

Yes. You may choose to have any number of advance directives, or to have none at all.

B. Durable Power of Attorney For Health Care

What is a *durable power of attorney for health care*?

A durable power of attorney for health care, also known as a health care proxy or a patient advocate designation, is a document in which you appoint another individual to make medical treatment and related personal care decisions for you.

You can, in addition, choose to give your patient advocate power to make decisions concerning mental health care you may need.

Finally, you can empower your patient advocate to donate specific organs or your entire body upon your death.

Is a durable power of attorney for health care legally binding?

Yes.

Who is eligible to have a durable power of attorney for health care?

You must be at least 18 years old, and you must understand you are giving another person power to make certain decisions for you should you become unable to make them.

What is the person to whom I give decision-making power called?

That person is known as your *patient advocate.*

When can the patient advocate act in my behalf?

Your patient advocate can make decisions for you only when you become unable to participate in medical treatment decisions yourself. Until that time, you make your own decisions directly.

If you choose to give your patient advocate power to make decisions about mental health treatment, your patient advocate can only act if you cannot give informed consent to mental health treatment.

How might I become unable to participate in medical or mental health decisions?

You might have a temporary loss of ability to make or communicate decisions if, for example, you had a stroke or were knocked unconscious in a car accident. You might suffer permanent loss through a degenerative condition, such as dementia.

You might become unable to make mental health decisions if a condition such as severe depression or schizophrenia affected your mood or thought process.

Who determines I am no longer able to participate in these decisions?

The doctor responsible for your care and one other doctor or psychologist who examines you will make that determination in the case of medical decisions.

After examining you, a doctor and a mental health professional (physician, psychologist, registered nurse or masters-level social worker) must each make the determination in respect to mental health treatment. You may in the document choose the doctor and mental health professional you wish to make this determination.

What if my religious beliefs prohibit an examination by a doctor?

You should state in your durable power of attorney document your religious beliefs prohibit an examination by a doctor, and how you want it determined you are unable to participate in health care decisions.

What powers can I give a patient advocate?

You can give a patient advocate power to make those personal care decisions you normally make for yourself. For example, you can give your patient advocate power to consent to or refuse medical treatment for you; arrange for mental health treatment, home health care or adult day care; or admit you to a hospital, nursing home or home for the aged.

You can also authorize your patient advocate to make a gift of your organs or body, to be effective upon your death.

Will my patient advocate have power to handle my financial affairs?

You can give your patient advocate power to arrange for medical and personal care services, and to pay for those services using your funds. Your patient advocate will not have general power to handle all your property and finances.

If you wish another person to handle all your property and financial affairs should you become incapacitated, you could seek a lawyer's help to draft a *durable power of attorney for finances* or a *living trust*.

Can I give my patient advocate the right to withhold or withdraw treatment that would allow me to die?

Yes, but you must express in a clear and convincing manner the patient advocate is authorized to make such decisions, and you must acknowledge these decisions could or would allow your death.

Can I authorize my patient advocate to decide to withhold or withdraw food and water administered through tubes?

Yes. If you want to give you patient advocate this authority, describe in the document the specific circumstances in which he or she can act - terminal illness, and permanent unconsciousness, for example.

Do I have the right in the document to express other wishes?

Yes. You might, for example express your wishes concerning other types of care you want during terminal illness. You could also express a desire not to be placed in a. nursing home and a desire to die at home. Your patient advocate has a duty to try to follow your wishes.

What are my options about mental health care?

First, you have a choice whether or not to give your patient advocate any powers concerning mental health care.

If you choose to give your patient advocate powers concerning mental health care, you should specify clearly which powers he or she can exercise. Some powers to consider are outpatient treatment, hospitalization, administration of psychotropic medication, and electro-convulsive therapy (ECT).

You can also provide greater detail - what hospital you prefer and what medications you want or don't want, for instance.

What are my options concerning organ donation?

You can choose whether or not to give your patient advocate this power.

If you wish your patient advocate to have this power, you can specify which organs you want donated, or whether your whole body is to be donated. You can specify where or to whom you wish your organs donated.

You can also complete the separate form in this booklet, *Declaration of Anatomical Gift*. If you state your wishes both in the durable power of attorney and in the declaration of anatomical gift, make sure your wishes are the same in both documents.

Is it important to express my specific wishes in an advance directive?

Your wishes cannot be followed if no one is aware of them. It can also be a burden for your advocate to make a decision for you without guidance. If you have specific desires, make these clear to your patient advocate in talking to him or her. Also consider including these wishes in the document.

What is the duty of my patient advocate?

Your patient advocate has a duty to take reasonable steps to follow your desires and instructions, oral and written, expressed while you were able to participate.

Are there exceptions?

A mental health professional can refuse to honor your wishes concerning a specific mental health treatment, location or professional, if there is a psychiatric emergency endangering your life or the life of another person.

What if I don't express any specific wishes concerning medical treatment?

Your patient advocate must then make decisions about medical care in what he or she sees as your best interest.

Will a hospital or nursing home allow my patient advocate to review my records?

Yes. A patient has the right to inspect and copy his or her hospital or nursing home records. Your patient advocate has the same right you have, once you are unable to participate in treatment decisions.

The form in this pamphlet allows a patient advocate to have access to your medical records at any time after you appoint him or her.

Whom can I appoint as patient advocate?

Any person age 18 or older is eligible; you can appoint your spouse, an adult child, a friend or other individual. You should choose someone you trust, who can handle the responsibility, and who is willing to serve.

It is a good idea to speak with the individual you propose to name as patient advocate before you complete and sign the document.

Can I appoint a second person to serve as patient advocate in case the first person is unable to serve?

Yes. It is a good idea to do so. There is no provision in law to allow more than one person to serve at the same time.

What must I do to have a valid durable power of attorney for health care?

The declaration must be in writing, signed by you, and witnessed by two adults.

There are restrictions on who can be a witness. You need witnesses who are not family members, not your doctor or proposed patient advocate, not an employee of a health facility or program where you are a patient or client.

What does a patient advocate need to do before acting in my behalf?

Before the patient advocate can act, he or she must sign an *acceptance.* This can be done at the time you complete the document or at a later time. The general language of the acceptance is set forth in law.

Is there a required form for the document?

No. You may choose to use the sample form in this pamphlet. There are a number of organizations that provide different, free forms.

Make sure in completing any document you type or print clearly.

Must I use a fill-in-the-blanks form?

No. You may write out your own document or have a lawyer draft a document for you. Using the form in this pamphlet is one option you have.

Once I sign a durable power of attorney, may I change my mind?

Yes. You may want to name a different patient advocate or alter the expression of your wishes. So long as you are of sound mind, you can sign a new document and then destroy the old one.

Regardless of your physical or mental condition, you can revoke or cancel the durable power of attorney by indicating in any way the document does not reflect your current wishes. Also, any spoken wish to have a specific life-extending treatment provided must be honored by a patient advocate, even if the wish contradicts a written directive.

Are there different rules for mental health treatment?

Yes. You can choose to waive your right to immediately revoke the durable power of attorney insofar as mental health treatment. In such case, your revocation is effective 30 days after you communicate your intent.

Can my patient advocate refuse to act in my behalf?

Yes. A patient advocate can revoke his or her Acceptance at any time. If so, your named successor would become patient advocate.

What if there is a dispute when my patient advocate is making decisions for me?

If an interested person disputes whether the patient advocate is acting in your best interests, or has the authority to act in your behalf, the interested person may petition the local probate court to resolve the dispute.

What if I regain the ability to participate in medical or mental health decisions?

The powers of your patient advocate are suspended during the time you are able to participate in decisions.

What if I have no one to appoint as a patient advocate?

You can still complete a living will or a do-not-resuscitate declaration, or both.

C. Living Will

What is a *living will*?

A living will is a written document in which you inform doctors, family members and others what type of medical care you wish to receive should you become terminally ill or permanently unconscious.

When will a living will take effect?

A living will only takes effect after a doctor diagnoses you as terminally ill or permanently unconscious and determines you are unable to make or communicate decisions about your care.

How is a living will different from a durable power of attorney for health care?

Although there can be overlap, the focus of a durable power is on *who* makes the decision; the focus of a living will is on *what* the decision should be.

A living will is limited to care during terminal illness or permanent unconsciousness, while a patient advocate may also have authority in circumstances of temporary disability.

A durable power of attorney for health care may be more flexible because your patient advocate can respond to unexpected circumstances, but a living will might be honored without the presence of a third person making the actual decision.

What might a living will say?

You might express your wishes in general terms - "Do whatever is necessary for my comfort, but nothing further." Or, "I authorize all measures be taken to prolong my life."

You might instead state whether or not you wish specific medical interventions, such as a respirator, cardiopulmonary resuscitation (CPR), surgery, antibiotic medication, and blood transfusions. You could authorize experimental or non-traditional treatment.

Whichever approach you choose, you should express your wishes concerning food and water administered through tubes.

Is a living will legally binding on health care providers?

Although 47 states have statutes giving living wills legal force, Michigan has not passed such a law. However, based on a Michigan court decision, there is an argument living wills are binding in this state. No one, however, can provide absolute assurance your wishes will be honored.

Is it worth having a living will?

Yes. It is particularly important to have a living will if you don't have a durable power of attorney for health care. Your wishes cannot be honored if they are not known.

Can I have both a durable power of attorney for health care and a living will?

Yes. Your patient advocate can read your living will as an expression of your wishes. The living will might also be valuable if your patient advocate were unavailable when a decision needed to be made.

If you have both documents, make sure your wishes expressed in the documents are consistent.

What are the requirements for a living will?

Since there is no state law, there are no formal requirements. But it is strongly recommended the document be entitled, "Living Will;" be dated; signed by you; and signed by two witnesses who are not family members.

D. Do-Not-Resuscitate Declaration

What is a *do-not-resuscitate declaration*?

A do-not-resuscitate declaration (DNR declaration) is a written document in which you express your wish that if your breathing and heartbeat cease, you do not want anyone to attempt to resuscitate you.

For whom might such a document be particularly useful?

A hospice patient who is home to die as peacefully as possible might wish to sign a DNR declaration.

Must I be terminally ill before signing a DNR declaration?

No. For example, you may be in good health but still not want to be resuscitated should your heart and lungs fail.

Are such documents legally binding?

Yes. A Michigan law provides these documents are valid in settings *other* than hospitals or nursing homes.

Are there standard forms for a DNR declaration?

Yes. One form provides spaces for your doctor to sign, for you to sign, and for two witnesses to sign.

There is an alternate form for individuals who have religious beliefs against using doctors. Both forms are included in this booklet.

Can my patient advocate sign the form instead of me?

If your patient advocate has authority to act, he or she can sign the form instead of you.

Is it necessary to have a DNR declaration if I have a durable power of attorney or living will?

Perhaps. A durable power of attorney for health care and a living will only take effect when you are unable to participate in treatment decisions. If you are competent until the moment your heart and breathing stop, these documents will never take effect.

What else can be done to prevent unwanted resuscitation?

Ask your relatives in advance not to call 9-1-1 or the police if your breathing should stop. If you are under the care of a registered nurse, she or he has the authority to pronounce death.

What about when I am in a nursing home or hospital?

These facilities can set their own policies about resuscitation. Upon admission or afterward, you should express your wishes on this issue and ask that these wishes be reflected on your medical chart.

E. General Information

In general, what should I do before completing an advance directive?

Take your time; these are difficult decisions. Think about what treatment you would like under various circumstances in the future. Consider whom you might choose as your patient advocate, and make sure that person is willing to serve.

Discuss the issue with family members. Talk with your minister, rabbi, priest or other spiritual leader if you feel it would be helpful.

Should I also talk with my doctor?

Yes! Bring the subject up with your doctor. Have a discussion about the benefits and burdens of various types of treatment. Express at least your general wishes and make sure the doctor is comfortable with carrying them out.

Are there issues to which I should give particular attention?

Yes. Many people have strong feelings about the administration of food and water. If you become unable to swallow, food and water can be supplied by a tube down your throat, a tube surgically placed into your stomach, or intravenously. Consider in what circumstances, if any, you wish such procedures withheld or withdrawn.

What should I do with an advance directive after it is signed?

Give the original durable power of attorney for health care to your patient advocate (or at least make sure she or he knows where it is). Give a photostatic copy to your doctor and keep a copy yourself. Let people know whom you have chosen as your patient advocate.

Keep the original of a living will. Give a copy to family members who are close to you, a friend and your doctor. Keep a list of these people.

Your doctor should make the documents part of your medical record. If you enter a hospital or nursing home, try to see to it the facility has a copy.

What about a do-not-resuscitate declaration?

Always keep the order with you at home, and in plain sight. Give a copy to family members who might be with you at your death.

After I sign one or more advance directives, should I continue to discuss the issue of my care?

Yes. Sit down with the person you have chosen as patient advocate. The clearer picture he or she has of your wishes, the better. If some time has passed since you signed the document, discuss the issue again.

It is almost always a good idea for you to make relatives and friends aware of your desires.

When I should review an advance directive?

Since medical technology is constantly changing, and since there may be changes in your outlook, it would be wise to review your advance directives once a year. Upon review, you can decide to keep the document, write a new one, or have no advance directive at all.

If you decide to keep the advance directive, you can put your initials and the date on the bottom.

What should I do if I write a new advance directive?

Whether you choose a different person to be your patient advocate or alter your wishes for care, try to get back copies of the old document and destroy them. Distribute copies of the new document.

What are the responsibilities of health care facilities?

Hospitals, nursing homes, hospice organizations and home health agencies receiving federal funds have an obligation to inform incoming patients of their rights to consent to or refuse treatment, including the right to have advance directives.

A health care facility cannot force you to sign an advance directive, or refuse to care for you if you have signed one.

If given an advance directive, the hospital or nursing home must make it part of your medical record.

Will the hospital or nursing home honor my advance directive?

If the facility has no reason to question the document's authenticity, has evidence you are no longer able to participate in treatment decisions, and believes a patient advocate is acting consistent with your wishes, the facility would likely comply.

Be aware even though you have an advance directive, there is no absolute assurance your wishes will be honored.

What if I decide not to have an advance directive?

Decisions would still have to be made for you should you become unable to make them. Sometimes, a doctor or hospital will accept a spouse or child as an informal decision-maker. In some situations, a family member has authority by law. At other times a guardianship proceeding will have to be initiated in probate court.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, am of sound mind and I
(Print or type your full name)
voluntarily make this designation.

APPOINTMENT OF PATIENT ADVOCATE

I designate _____, my _____
(Insert name of patient advocate) (Spouse, child, friend …)

living at _____
(Address of patient advocate)
as my patient advocate. If my first choice cannot serve, I designate _____, my _____, living at
(Name of successor patient advocate) (Spouse, child, friend ...)

_____
(Address of successor patient advocate)
to serve as patient advocate.

My patient advocate or successor patient advocate must sign an acceptance before he or she can act. I have discussed this appointment with the individuals I have designated as patient advocate and successor patient advocate.

GENERAL POWERS

My patient advocate or successor patient advocate shall have power to make care, custody and medical treatment decisions for me if my attending physician and another physician or licensed psychologist determine I am unable to participate in medical treatment decisions.

In making decisions, my patient advocate shall try to follow my previously expressed wishes, whether I have stated them orally, in a living will, or in this designation.

My patient advocate has authority to consent to or refuse treatment on my behalf, to arrange medical and personal services for me, including admission to a hospital or nursing care facility, and to pay for such services with my funds.

My patient advocate shall have access to any of my medical records to which I have a right, immediately upon signing an Acceptance. This shall serve as a release under the Health Insurance Portability and Accountability Act.

Immediately upon signing an Acceptance, my patient advocate shall have access to my birth certificate and other legal documents needed to apply for Medicare, Medicaid, and other government programs.

POWER REGARDING LIFE-SUSTAINING TREATMENT
(OPTIONAL)

I expressly authorize my patient advocate to make decisions to withhold or withdraw treatment which would allow me to die, and I acknowledge such decisions could or would allow my death. My patient advocate can sign a do-not-resuscitate declaration for me. My patient advocate can refuse food and water administered to me through tubes.

_____

(Sign your name if you wish to give your patient advocate this authority)

POWER REGARDING MENTAL HEALTH TREATMENT
(OPTIONAL)

I expressly authorize my patient advocate to make decisions concerning the following treatments if a physician and a mental health professional determine I cannot give informed consent for mental health care:

(check one or more consistent with your wishes)

❑ outpatient therapy

❑ my admission as a formal voluntary patient to a hospital to receive inpatient mental health services. I have the right to give three days notice of my intent to leave the hospital.

❑ my admission to a hospital to receive inpatient mental health services

❑ psychotropic medication

❑ electro-convulsive therapy (ECT)

❑ I give up my right to have a revocation effective immediately. If I revoke my designation, the revocation is effective 30 days from the date I communicate my intent to revoke. Even if I choose this option, I still have the right to give three days notice of my intent to leave a hospital if I am a formal voluntary patient.

_____

(Sign your name if you wish to give your patient advocate this authority)

POWER REGARDING ORGAN DONATION
(OPTIONAL)

I expressly authorize my patient advocate to make a gift of the following -

(check any that reflect your wishes)

❑ any needed organs or body parts for the purposes of transplantation, therapy, medical research or education

❑ only the following listed organs or body parts for the purposes of transplantation, therapy, medical research or education: _____

❑ my entire body for anatomical study

❑ (optional) I wish my gift to go to -

_____

(Insert name of doctor, hospital, school, organ bank or individual)

The gift is effective upon my death. Unlike other powers I give to my patient advocate, this power remains after my death.

_____

(Sign your name if you wish to give your patient advocate this authority)

STATEMENT OF WISHES

My patient advocate has authority to make decisions in a wide variety of circumstances. In this document, I can express general wishes regarding conditions such as terminal illness, permanent unconsciousness, or other disability; specify particular types of treatment I do or not want in such circumstances; or I may state no wishes at all. If you have chosen to give your patient advocate power concerning mental health treatment, you can also include specific wishes about mental health treatment such as a preferred mental health professional, hospital or medication.

A. My wishes are as follows (you may attach more sheets of paper):

_____
_____
_____
_____
_____
_____
_____

or

B. I choose not to express any wishes in this document. This choice shall not be interpreted as limiting the power of my patient advocate to make any particular decision in any particular circumstance.

I may change my mind at any time by communicating in any manner that this designation does not reflect my wishes.

It is my intent no one involved in my care shall be liable for honoring my wishes as expressed in this designation or for following the directions of my patient advocate.

Photocopies of this document can be relied upon as though they were originals.

SIGNATURE

I sign this document voluntarily, and I understand its purpose.

Dated: _____

Signed: _____
(Your signature)

_____
(Address)

STATEMENT REGARDING WITNESSES

I have chosen two adult witnesses who are not named in my will; who are not my spouse, parent, child, grandchild, brother or sister; who are not my physician or my patient advocate; who are not an employee of my life or health insurance company, an employee of a home for the aged where I reside, an employee of community mental health program providing me services or an employee at the health care facility where I am now.

STATEMENT AND SIGNATURE OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

_____ _____

(Print name) (Signature of witness)

_____

(Address)

_____ _____

(Print name) (Signature of witness)

_____

(Address)

ACCEPTANCE BY PATIENT ADVOCATE

(1) This designation shall not become effective unless the patient is unable to participate in decisions regarding the patient's medical or mental health, as applicable. If this patient advocate designation includes the authority to make an anatomical gift as described in section 5506, the authority remains exercisable after the patient's death.

(2) A patient advocate shall not exercise powers concerning the patient's care, custody and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.

(3) This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

(4) A patient advocate may make a decision to withhold or withdraw treatment which would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

(5) A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

(6) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental heath treatment decisions are presumed to be in the patient's best interests.

(7) A patient may revoke his or her designation at any time or in any manner sufficient to communicate an intent to revoke.

(8) A patient may waive his or her right to revoke the patient advocate designation as to the power to make mental health treatment decisions, and if such waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

(9) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

(10) A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, Being Section 333.20201 of the Michigan Compiled Laws.

I, _____, understand the above
(Name of patient advocate)
conditions and I accept the designation as patient advocate or successor patient advocate for _____, who signed a
(Name of patient)
durable power of attorney for health care on the following date: _____.

Dated: _____

Signed: _____
(Signature of patient advocate or successor patient advocate)

Living Will

I, _____ am of sound mind, and I voluntarily make this declaration.

If I become terminally ill or permanently unconscious as determined by my doctor and at least one other doctor, and if I am unable to participate in decisions regarding my medical care, I intend this declaration to be honored as the expression of my legal right to authorize or refuse medical treatment.

My desires concerning medical treatment are -

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

My family, the medical facility, and any doctors, nurses and other medical personnel involved in my care shall have no civil or criminal liability for following my wishes as expressed in this declaration.

I may change my mind at any time by communicating in any manner that this declaration does not reflect my wishes.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I sign this document after careful consideration. I understand its meaning and I accept its consequences.

Dated: _____ Signed: _____
(Your signature)

_____

_____
(Address)

STATEMENT OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

_____ _____
(Print Name) (Signature of Witness)

_____

_____
(Address)

_____ _____
(Print Name) (Signature of Witness)

_____

_____
(Address)

DO-NOT-RESUSCITATE ORDER

I have discussed my health status with my physician, _____. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me.

This order is effective until it is revoked by me.

Being of sound mind, I voluntarily execute this order, and I understand its full import.

_____ (Declarant's signature) _____ (Date)

_____ (Type or print declarant's full name)

_____ (Signature of person who signed for declarant, if applicable) _____ (Date)

_____ (Type or print full name)

_____ (Physician's signature) _____ (Date)

_____ (Type or print physician's full name)

ATTESTATION OF WITNESSES

The individual who has executed this order appears to be of sound mind, and under no duress, fraud, or undue influence. Upon executing this order, the individual has (has not) received an identification bracelet.

_____ (Witness signature) (Date) _____ (Witness signature) (Date)

_____ (Type or print witness's name) _____ (Type or print witness's name)

THIS FORM WAS PREPARED PURSUANT TO, AND IN COMPLIANCE WITH, THE MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT

DO-NOT-RESUSCITATE ORDER

I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me.

This order is effective until it is revoked by me.

Being of sound mind, I voluntarily execute this order, and I understand its full import.

_____ _____
(Declarant's signature) (Date)

_____
(Type or print declarant's full name)

_____ _____
(Signature of person who signed for declarant, if applicable) (Date)

_____
(Type or print full name)

ATTESTATION OF WITNESSES

The individual who has executed this order appears to be of sound mind, and under no duress, fraud, or undue influence. Upon executing this order, the individual has (has not) received an identification bracelet.

_____ _____
(Witness signature) (Date) (Witness signature) (Date)

_____ _____
(Type or print witness's name) (Type or print witness's name)

THIS FORM WAS PREPARED PURSUANT TO, AND IN COMPLIANCE WITH, THE MICHIGAN DO-NOT-RESUSCITATE PROCEDURE ACT

Declaration of Anatomical Gift

I, _____, am of sound mind, and I voluntarily make this declaration. In the hope I may help others, I make the following anatomical gift to take effect upon my death: (You may check any one box, or both boxes A and C)

☐ A. Any needed organs or body parts for the purposes of transplantation, therapy, medical research or education.

☐ B. Only the following listed organs or body parts for the purposes of transplantation, therapy, medical research or education: _____, _____, _____.

☐ C. My entire body for anatomical study.

Dated: _____ Signed: _____
(Your Signature)

_____
(Address)

OPTIONAL

I wish my gift to go to _____.
(Insert name of doctor, hospital, school, organ bank or individual)

I wish to have my body at my funeral: yes ☐ no ☐

STATEMENT OF WITNESSES

This declaration was signed in our presence by the declarant or at his or her direction. We sign below as witnesses in the presence of the declarant.

_____ _____
(Print Name) (Signature of Witness)

_____
(Address)

_____ _____
(Print Name) (Signature of Witness)

_____
(Address)