

ADVANCE DIRECTIVE
APPOINTMENT OF HEALTH CARE AGENT
AND
HEALTH CARE INSTRUCTIONS

For

I, _____, Date of Birth: _____; Social Security Number: _____ residing at _____, _____, Maryland _____, a legal resident of Maryland appoint the following individual as my Health Care Agent, hereinafter referred to as "AGENT" to make health care decisions for me: my _____, _____, residing at _____, _____, Maryland _____; telephone number (home) _____. In the event that my designated Agent is unable or unwilling to continue in that capacity, the Agent shall be empowered to appoint a successor.

Revocation

I hereby revoke all other Health Care or Medical Powers of Attorney that I may have made heretofore.

Durability

This Advance Directive shall be durable, in that it shall not be affected by my disability, and shall remain in full force and effect until the occurrence of the first of the following circumstances: (1) my death; (2) the death or disability of my Agent; (3) my revocation of this Advance Directive.

Effectiveness

This Advance Directive shall be effective only upon my becoming disabled and unable to give an informed consent to medical procedures and shall not be effective until then. In lieu of a judicial determination of my disability, I shall be presumed disabled and this Advance Directive shall become effective only upon presentation of two (2) medical certificates, dated and signed by two (2) physicians under oath stating that each physician has personally examined or treated me and further stating that in each physician's opinion I am disabled. Any person, organization, or entity may rely on such medical certificates as evidencing my disability provided that such certificates were not made more than one (1) year prior to the date my Agent acts on my behalf.

Agent's Authority

My agent has full power and authority to make health care decisions for me, including the power to:

Initials

A. Request, receive and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and consent to disclosure of this information and emotion well-being.

B. Employ for reasonable compensation and discharge medical personnel including physicians, psychiatrists, dentists, nurses, and therapists as my Agent shall deem necessary for my physical, mental and emotional well-being.

C. Authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult home, or other medical care facility.

D. Consent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life-sustaining procedures.

E. Upon execution of a certificate by two independent psychiatrists who have examined me and in whose opinions I am in immediate need of inpatient treatment because of mental disorders, alcoholism or drug abuse, consent to my voluntary admission to an appropriate hospital or institution for treatment of the diagnosed problem or disorder; to arrange for private psychiatric and psychological treatment for me; and to revoke, modify, withdraw or change consent to any hospitalization, institutionalization or treatment previously given by me or my Agent. My Agent's consent to my hospitalization for treatment of such mental disorder, alcoholism or drug abuse, shall have the same legal effect, subject to applicable local law, as voluntary admission made by me.

F. Exercise my right of privacy to make decisions regarding my medical treatment including my right to be left alone even though to exercise my right might hasten my death or be against conventional medical advice.

G. Consent to and arrange for the administration of pain-relieving drugs of any kind, or other surgical or medical procedures calculated to relieve my pain even though their use may lead to permanent physical damage, addiction or even hasten the moment of (but not intentionally cause) my death; and to authorize, consent to and arrange for unconventional pain relief therapies which my Agent believes may be helpful to me.

H. Grant releases to hospital staff, physicians, nurses and other medical and hospital administrative personnel who act in reliance on instruction given by my Agent or who render written opinions to my Agent from all liability for damages suffered or to be suffered by me; to sign documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice" as well as any necessary waivers or releases from liability required by any hospital or physician to implement my wishes regarding medical treatment or non-treatment.

Provisions Governing Agent's Authority

My Agent is to make health care decisions for me based on the health care instructions I give in this document and on my wishes as otherwise known to my Agent. Any other advance

directive, such as a Living Will, duly executed by me, shall be cumulative in effect with this document and shall not restrict the powers within. If my wishes are unknown or unclear, my Agent is to make health care decisions for me in accordance with my best interests, to be determined by my Agent after considering the benefits, burdens, and risks that might result from a given treatment or course of treatment.

If I am incapable of making an informed decision regarding my health care, I direct my Agent to consider the following provisions:

If my death from a terminal condition is imminent and even if life-sustaining procedures are used and there is no expectation of my recovery, I direct that my life not be extended by life-sustaining procedures including, but not limited to, surgery, cardio-pulmonary resuscitation, mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, chemotherapy, radiation and other forms of medical treatment which stimulate or maintain vital bodily functions.

If I am in a persistent vegetative state, that is, if I am not conscious and am not aware of my environment or able to interact with others, and there is no reasonable expectation of my recovery, I direct that my life not be extended by life-sustaining procedures including, but not limited to, surgery, cardio-pulmonary resuscitation, mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, chemotherapy, radiation and other forms of medical treatment which stimulate or maintain vital bodily functions.

If I have an end-stage condition, that is a condition caused by injury, disease, or illness, as a result of which I have suffered severe and permanent deterioration indicated by incompetency and complete physical dependency and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective, I direct that my life not be extended by life-sustaining procedures including, but not limited to, surgery, cardio-pulmonary resuscitation, mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, chemotherapy, radiation and other forms of medical treatment which stimulate or maintain vital bodily functions.

If I am in a coma, I direct that my life not be extended by life-sustaining procedures including, but not limited to, surgery, cardio-pulmonary resuscitation, mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, chemotherapy, radiation and other forms of medical treatment which stimulate or maintain vital bodily functions.

In addition to my choices, as designated above, regarding the acceptance, refusal or withdrawal of medical treatment, I specifically direct that sufficient medication be administered to relieve pain and discomfort, without regard to whether or not the doses required will hasten my death.

Religious Beliefs or Moral Convictions

It is my desire that medical treatments shall not be rejected for such reasons.

Guardianship

I request that no proceeding for guardianship of the person be commenced in the event of my disability. Should such a proceeding be commenced, it is my desire that my Agent or successor serve as my guardian of person.

Photocopies

I hereby authorize the use of a photocopy of this Advance Directive, in lieu of the original copy executed by me, for the purposes of effectuating the terms and provisions hereof.

Health Care Providers

A health care provider shall not be subject to criminal prosecution, civil liability, or professional disciplinary action if such health care provider relies on a health care decision made by my Agent, who the health care provider believes in good faith is authorized to make health care decisions for me.

I direct that my Agent notify any health care provider whose care I am under of the existence of this advance directive in the event that I am comatose, incompetent or otherwise incapable of communication. This grant of authority shall not preclude any other person from notifying my health care provider of the existence of this advance directive in the event I am comatose, incompetent or otherwise incapable of communication.

Agent Liability

My Agent shall not be subject to criminal prosecution or civil liability for any action taken pursuant to this grant of authority. The absence of such liability in my Agent shall extend to my heirs, legal and personal representatives, and assigns.

My Agent shall not be liable for the costs of care based solely on this authorization.

In the event I revoke this instrument by notice to my Agent prior to any disability, and third party acting on the authority of this instrument, and without knowledge of the revocation, my Agent shall not be held accountable for any loss to me, my estate, heirs, successors or assigns.

By signing below, I indicate that I am emotionally and mentally competent to make this appointment of a health care agent and that I understand its purpose and effect.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this _____ day of _____, 20____.

_____(SEAL)

The Declarant signed or acknowledged signing this Advance Directive in my presence and based upon my personal observation appears to be a competent individual.

WITNESS SIGNATURE

WITNESS SIGNATURE

Print Name:_____

Print Name:_____

Address:_____

Address:_____

Date:_____

Date:_____

AT LEAST ONE OF THE WITNESSES LISTED ABOVE SHALL ALSO SIGN THE FOLLOWING DECLARATION

I further declare that I am not related to the patient by blood, marriage or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the patient under a currently existing will or by operation of law.

Signature:_____

Signature:_____

STATE OF MARYLAND :
COUNTY OF _____ : **TO WIT:**

I the Undersigned, do hereby certify that I am duly commissioned, qualified, and authorized Notary Public in and for the aforesaid State and that the Declarant in the foregoing Advance Directive, who is known to me (or satisfactorily proven), appeared before me this day within the territorial limits of my authority and executed said instrument after the contents thereof had been read and duly explained to said Declarant and acknowledged that the execution of said instrument was the free and voluntary act and deed of said Declarant for the uses and purposes therein set forth.

IN WITNESS WHEREOF, I have hereunto set my Hand and affixed my official Seal
this _____ day of _____, 20____.

NOTARY PUBLIC

My Commission Expires: