

**ADVANCE DIRECTIVE**  
**YOUR DURABLE POWER OF ATTORNEY FOR HEALTH CARE, LIVING WILL**  
**AND OTHER WISHES**

*This document has been prepared and distributed as an informational service  
of the District of Columbia Hospital Association.*

**INSTRUCTIONS AND DEFINITIONS**

**INTRODUCTION:**

This form is a combined Durable Power of Attorney for Health Care and Living Will for use in the District of Columbia, Maryland and Virginia. With this form, you can:

- ◆ Appoint someone to make health care decisions for you if you are unable to make those decisions for yourself;
- and/or
- ◆ Indicate what health care treatments you do or do not want if you are unable to make your wishes known.

**DIRECTIONS:**

- ◆ Read each section carefully.
- ◆ Talk to the person you plan to appoint to make sure that he/she understands your wishes, and is willing to take the responsibility to follow your wishes.
- ◆ Place the initials of your name in the blanks before those choices you want to make.
- ◆ Fill in only those choices that you want under Parts 1, 2 and 3. Your advance directive should be valid for whatever parts you fill in, as long as it is properly signed.
- ◆ Add any special instructions in the blank spaces provided. You can write additional comments on a separate sheet of paper. If you add pages, you should indicate on the form that there are additional pages to your advance directive.
- ◆ Sign the form and have it witnessed.
- ◆ Give a copy of your advance directive to your doctor, your nurse, the person you appoint to make your health care decisions for you, your family, your clergy, your attorney and anyone else who might be involved with your care.
- ◆ Understand that you may change or cancel this document at any time.

## **WORDS YOU NEED TO KNOW:**

**Advance Directive:** A written document that tells what a person wants or does not want if in the future he/she cannot make his/her wishes known about health care treatment.

**Artificial Nutrition and Hydration:** When food and water are given to a person through a tube.

**Autopsy:** An examination done on a dead body to find the cause of death.

**Comfort Care :** Care that helps to keep a person comfortable. Pain relief, bathing, turning, keeping a person's lips moist are types of comfort care.

**CPR (Cardiopulmonary Resuscitation):** An attempt to try and restart a person's breathing or heartbeat. CPR may include pushing on the chest, putting a tube down the throat, and/or other treatment.

**Durable Power of Attorney for Health Care:** An advance directive that appoints someone to make health care decisions for a person if he/she cannot make or communicate his/her own decisions. That person may be a family member or a friend but does not need to be a lawyer. The person appointed must follow **your wishes** if they are known. If they are not known, the person must make decisions based on what he/she thinks **you** would want.

**End-Stage Condition:** A chronic, irreversible condition caused by injury or illness that has caused serious, permanent damage to the body. A person in an end-stage condition requires others to provide most of his/her care.

**Life-Sustaining Treatment:** Any health care treatment that is used to keep a person from dying. A breathing machine, CPR, dialysis, artificial nutrition and hydration are examples of life-sustaining treatment.

**Living Will:** An advance directive that tells what health care treatment a person does or does not want if he/she is not able to make his/her wishes known.

**Organ and Tissue Donation:** When a person permits his/her organs (such as eyes or kidneys) or other parts of the body (such as skin) to be removed after death to be transplanted for use by another person.

**Permanent Coma:** When a person is unconscious with no hope of regaining consciousness even with medical care. In a coma, a person is not awake or aware of surroundings.

**Persistent Vegetative State:** When a person has brain damage that makes him/her unaware of pain or surroundings and has no hope of improvement, even within maximum medical treatment. The eyes may be open and the body may move.

**Terminal Condition:** An advanced, irreversible condition caused by injury or illness that has no cure and from which doctors expect the person to die, even with maximum medical treatment. Life-



\_\_\_\_\_ I understand that if I do not appoint a Durable Power of Attorney for Health Care, someone may be designated to make my health care decisions by law or by a court.

*I want the person I have appointed, my doctors, my family and others to be guided by my wishes described on the following pages.*

## **PART 2. MY LIVING WILL**

***A. Use this page to help the person you have named in Part 1 make decisions for you, according to how you feel about certain medical conditions. This information may also be helpful to your doctor and others who will care for you.***

**In general, these should be the goals of my care if I have an end-stage or terminal condition or am in persistent vegetative state, with no hope of improvement:**

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**If I have an end-stage or terminal condition or am in persistent vegetative state, with no hope of improvement, and I am unable to recognize and communicate with my family/friends, these are my wishes:**

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**If I have an end-stage or terminal condition or am in persistent vegetative state, with no hope of improvement, and am unable to live independently and must live in an institution, these are my wishes:**

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**If I have an end-stage or terminal condition or am in persistent vegetative state, with no hope of improvement, and I must stay in bed for the rest of my life, these are my wishes:**

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**If I have an end-stage or terminal condition or am in persistent vegetative state, with no hope of improvement, and I am unable to care for myself (dressing, bathing, etc.), these are my wishes:**

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If I have an end-stage or terminal condition or am in persistent vegetative state, with no hope of improvement, **and I cannot eat by mouth and must be given food and water through tubes, these are my wishes:**

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***B. Use this page to describe treatments which may be offered if you are in an end-stage or terminal condition or persistent vegetative state, to help the person you named in Part 1 make decisions for you. This information may also be helpful to your doctor and others who will care for you.***

*(Put the initials of your name next to your choices.)*

**Treatment Choices:**

\_\_\_\_\_ I do not want life-sustaining treatments (such as CPR) started. If these treatments are started, I want them stopped. (Special notes: \_\_\_\_\_  
\_\_\_\_\_)

\_\_\_\_\_ I want life-sustaining treatments started on a temporary basis ; if I do not show signs of recovery, then I want them stopped. (Special notes: \_\_\_\_\_  
\_\_\_\_\_)

\_\_\_\_\_ Other wishes regarding life-sustaining treatments, including dialysis or other major medical treatments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Artificial Nutrition and Hydration** (such as a feeding tube):

\_\_\_\_\_ I do not want a feeding tube started if it would be the main treatment keeping me alive. If a feeding tube is started, I want it stopped. (Special notes: \_\_\_\_\_  
\_\_\_\_\_)

\_\_\_\_\_ I want a feeding tube started on a temporary basis; if I do not show signs of recovery, then I want it stopped. (Special notes: \_\_\_\_\_  
\_\_\_\_\_)

\_\_\_\_\_ I want artificial nutrition and hydration, even if it is the main treatment keeping me alive. (Special notes: \_\_\_\_\_  
\_\_\_\_\_)

\_\_\_\_\_ Other wishes regarding artificial nutrition and hydration: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **C. Other Directions**

You have the right to be involved in all decisions about your health care, even those not dealing with end-stage condition, terminal condition or persistent vegetative state. If you have wishes not covered in other parts of this document, please indicate them here:

\_\_\_\_\_

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## **PART 3. OTHER WISHES**

### **A. Organ Donation**

\_\_\_\_\_ I do not wish to donate any of my organs or tissues.  
\_\_\_\_\_ I want to donate all my organs and tissues.  
\_\_\_\_\_ I only want to donate these organs and/or tissues: \_\_\_\_\_

### **B. Autopsy**

\_\_\_\_\_ I do not want an autopsy.  
\_\_\_\_\_ I agree to an autopsy if my doctors wish it.  
\_\_\_\_\_ Other wishes: \_\_\_\_\_

## **PART 4. SIGNATURES**

**You must sign this document. Two people who are not your relatives should sign as witnesses. This document does not need to be notarized. Even if you cannot find witnesses, you should sign this and give it to your doctor as an indication of your wishes.**

### **A. Your Signature**

By my signature below, I show that I understand the purpose and the effect of this document.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

### **B. Your Witnesses' Signatures**

I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence, and that he/she appears not to be acting under pressure, duress, fraud or undue influence. I am not related to the person making this advance

directive by blood, marriage or adoption, nor, to the best of my knowledge, am I named in his/her will. I am not the person appointed in this advance directive. I am not a health care provider or an employee of a health care provider who is now, or has been in the past, responsible for the care of the person making this advance directive. I am over the age of 18.

**Witness #1**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

**Witness #2**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_