PART I

Part I. Health Care Proxy

PRINT YOUR NAME

I, _____, hereby appoint:
(name)

PRINT NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR AGENT

_____
(name, home address and telephone number of agent)

_____

as my health care agent.

In the event that the person I name above is unable, unwilling, or reasonably unavailable to act as my agent, I hereby appoint

PRINT NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT

_____
(name, home address and telephone number of agent)

_____

as my health care agent.

This health care proxy shall take effect in the event I become unable to make my own health care decisions.

My agent has the authority to make any and all health care decisions for me, except to the extent that I state otherwise here:

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT YOUR AGENT'S AUTHORITY

_____
_____
_____
_____
_____
_____

Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or condition I have stated below. This proxy shall expire (specific date or conditions, if desired):

SPECIFY THE DATE OR CONDITIONS FOR EXPIRATION, IF ANY

_____
_____
_____

When making health-care decisions for me, my agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my agent should make decisions for me that my agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

My agent should also consider the following instructions when making health care decisions for me:

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(Attach additional pages if needed)

Part II. NEW YORK HEALTH CARE PROXY AND LIVING WILL – PAGE 3 OF 6

PART II

This Living Will has been prepared to conform to the law in the State of New York, and is intended to be "clear and convincing" evidence of my wishes regarding the health care decisions I have indicated below.

PRINT YOUR NAME

I, _____, being of sound mind, make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to regarding health care under the circumstances indicated below:

LIFE-SUSTAINING TREATMENTS

I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (**Initial only one box**)

INITIAL ONLY ONE CHOICE: (a) OR (b)

IF YOU DO NOT AGREE WITH EITHER CHOICE, YOU MAY WRITE YOUR OWN DIRECTIONS ON THE NEXT PAGE

[ ] (a) **Choice NOT To Prolong Life**

I do not want my life to be prolonged if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery, including but not limited to: (a) a terminal condition; (b) a permanently unconscious condition; or (c) a minimally conscious condition in which I am permanently unable to make decisions or express my wishes. While I understand that I am not legally required to be specific about future treatments if I am in the condition(s) described above I feel especially strongly about the following forms of treatment:

IF YOU INITIAL BOX (a), YOU MAY INITIAL SPECIFIC TREATMENTS YOU WOULD LIKE WITHHELD

[ ] I do not want cardiac resuscitation.
[ ] I do not want mechanical respiration.
[ ] I do not want artificial nutrition and hydration.
[ ] I do not want antibiotics.

OR

[ ] (b) **Choice To Prolong Life**
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

RELIEF FROM PAIN:

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

ADD ADDITIONAL INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT PAIN RELIEF

_____
_____
_____
_____

OTHER WISHES:

(If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

_____
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These directions express my legal right to refuse treatment, under the law of New York. I intend my instructions to be carried out unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

My agent, if I have appointed one in Part I or elsewhere, has full authority to resolve any question regarding my health care decisions, as recorded in this document or otherwise, and what my choices may be.

ORGAN DONATION (OPTIONAL)

INITIAL THE BOX THAT AGREES WITH YOUR WISHES ABOUT ORGAN DONATION

INITIAL ONLY ONE

STRIKE THROUGH ANY USES YOU DO NOT AGREE TO

OPTIONAL ORGAN DONATION:

Upon my death: (initial only one applicable box)

[☐] (a) I do not give any of my organs, tissues, or parts and do not want my agent, guardian, or family to make a donation on my behalf;

[☐] (b) I give any needed organs, tissues, or parts;

OR

[☐] (c) I give the following organs, tissues, or parts only:

_____

_____

_____

My gift, if I have made one, is for the following purposes: (strike any of the following you do not want)

(1) Transplant
(2) Therapy
(3) Research
(4) Education

PART III

SIGN AND DATE THE DOCUMENT AND PRINT YOUR NAME AND ADDRESS

WITNESSING PROCEDURE

YOUR WITNESSES MUST SIGN AND DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

Part III. Execution

Signed _____ Date_____

Print Name_____

Address _____

_____

I declare that the person who signed this document appeared to execute the living will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1

Signed _____ Date_____

Print Name_____

Address _____

_____

Witness 2

Signed _____ Date_____

Print Name_____

Address _____

_____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800-658-8898