

# **ILLINOIS**

## **Advance Directive**

### **Planning for Important Health Care Decisions**

*CaringInfo*  
1731 King St., Suite 100, Alexandria, VA 22314  
[www.caringinfo.org](http://www.caringinfo.org)  
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

#### **It's About How You LIVE**

*It's About How You LIVE* is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and health care providers
- E**ngage in personal or community efforts to improve end-of-life care

**Note:** The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

## Using These Materials

### BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.
2. These materials include:
  - Instructions for preparing your advance directive, please read all the instructions.
  - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

### ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.
5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

## INTRODUCTION TO YOUR ILLINOIS ADVANCE DIRECTIVE

This packet contains two legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

The **Illinois Statutory Short Form Power of Attorney for Health Care** lets you name someone — your agent — to make decisions about your medical care if you can no longer speak for yourself. The form lets you set down your wishes regarding organ donation, life-sustaining treatment, burial arrangements, and other advance-planning issues to help your agent make these decisions.

The power of attorney for health care is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Your power of attorney for health care goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

This form does not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Following the Illinois Power of Attorney for Health Care is an **Illinois Living Will**. This document allows you to direct that, if you are suffering from a terminal condition, death-delaying procedures will not be utilized to prolong your life. The Illinois Living Will is limited to this instruction and is not effective if you have an effective power of attorney for health care. The Illinois Living Will is useful if you do not want to name an agent and you want to avoid prolonging your life in the event you have a terminal condition.

*Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).*

## **COMPLETING YOUR ILLINOIS POWER OF ATTORNEY FOR HEALTH CARE AND ILLINOIS LIVING WILL**

### **How do I make my Illinois Power of Attorney for Health Care and my Illinois Living Will legal?**

The Illinois Statutory Short Form, on which the following power of attorney for health care form is based, requires that your signature be witnessed by one adult, 18 years of age or older. Your witness cannot be:

- Your attending physician, advanced practice nurse, physician assistant, dentist, podiatric physician, optometrist, or mental health service provider or a relative thereof;
- An owner, operator, or relative of an owner or operator of a health care facility in which you are a patient or resident;
- Your parent, sibling, descendant, or any of their spouses;
- Your agent's parent, sibling, or descendant, or any of their spouses; or
- Your agent or successor agent.

The Illinois statutory living will form, on which the following living will form is based, requires that your signature be witnessed by two adults, 18 years of age or older. The witnesses cannot be a person signing on your behalf, directly financially responsible for your medical care, or entitled to any portion of your estate. As noted above, an Illinois Living Will is not effective if you have a valid Illinois Power of Attorney for Health Care in place.

*Note: You may sign your document by hand or electronically. You do not need to notarize your power of attorney for health care or your living will.*

### **Whom should I appoint as my agent?**

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

You can appoint a second and third person as your successor agents. The successor agents will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

Your agent may not be your attending physician or any other health care provider who is administering health care to you at the time you execute this document.

## **COMPLETING YOUR ILLINOIS POWER OF ATTORNEY FOR HEALTH CARE AND ILLINOIS LIVING WILL (continued)**

### **Should I add personal instructions to my Illinois Power of Attorney for Health Care?**

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

### **What if I change my mind?**

You may revoke your Illinois power of attorney for health care or your Illinois living will at any time by:

- obliterating, burning, tearing, or otherwise destroying or defacing your document,
- signing and dating a written revocation, or directing another to do so for you, regardless of whether the written revocation is in electronic or hard copy format,
- expressing your intent, orally or otherwise, to revoke the document in the presence of a witness 18 years of age or older, who must sign and date a written confirmation that you expressed your intent to revoke, or
- for an electronic declaration, by deleting in a manner indicating the intention to revoke, using a generic, technology-neutral system in which each user is assigned a unique identifier that is securely maintained and in a manner that meets the regulatory requirements for a digital or electronic signature.

Revocation of your living will is not effective until it is communicated to your attending physician.

You also may amend your power of attorney for health care at any time by a written amendment signed and dated by you or another person acting at your direction.

You may also choose a delayed revocation by initialing the appropriate box in the power of attorney form – this will create a 30-day waiting period such that your revocation of your power of attorney will not take effect until 30 days after you voice the intent to revoke.

**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR  
HEALTH CARE – PAGE 1 OF 12**

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NOTICE TO THE INDIVIDUAL SIGNING  
THE POWER OF ATTORNEY FOR HEALTH CARE

STATUTORY NOTICE

No one can predict when a serious illness or accident might occur. When it does, you may need someone else to speak or make health care decisions for you. If you plan now, you can increase the chances that the medical treatment you get will be the treatment you want.

In Illinois, you can choose someone to be your “health care agent”. Your agent is the person you trust to make health care decisions for you if you are unable or do not want to make them yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of agent in writing. The written form is often called an “advance directive”. You may use this form or another form, as long as it meets the legal requirements of Illinois. There are many written and on-line resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing your advance directive.

**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR  
HEALTH CARE — PAGE 2 OF 12**

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WHAT ARE THE THINGS I WANT MY  
HEALTH CARE AGENT TO KNOW?

The selection of your agent should be considered carefully, as your agent will have the ultimate decision-making authority once this document goes into effect, in most instances after you are no longer able to make your own decisions. While the goal is for your agent to make decisions in keeping with your preferences and in the majority of circumstances that is what happens, please know that the law does allow your agent to make decisions to direct or refuse health care interventions or withdraw treatment. Your agent will need to think about conversations you have had, your personality, and how you handled important health care issues in the past. Therefore, it is important to talk with your agent and your family about such things as:

(i) What is most important to you in your life?

(ii) How important is it to you to avoid pain and suffering?

(iii) If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?

(iv) Would you rather be at home or in a hospital for the last days or weeks of your life?

(v) Do you have religious, spiritual, or cultural beliefs that you want your agent and others to consider?

(vi) Do you wish to make a significant contribution to medical science after your death through organ or whole body donation?

(vii) Do you have an existing advance directive, such as a living will, that contains your specific wishes about health care that is only delaying your death? If you have another advance directive, make sure to discuss with your agent the directive and the treatment decisions contained within that outline your preferences. Make sure that your agent agrees to honor the wishes expressed in your advance directive.

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WHAT KIND OF DECISIONS CAN MY AGENT MAKE?

If there is ever a period of time when your physician determines that you cannot make your own health care decisions, or if you do not want to make your own decisions, some of the decisions your agent could make are to:

(i) talk with physicians and other health care providers about your condition.

(ii) see medical records and approve who else can see them.

(iii) give permission for medical tests, medicines, surgery, or other treatments.

(iv) choose where you receive care and which physicians and others provide it.

(v) decide to accept, withdraw, or decline treatments designed to keep you alive if you are near death or not likely to recover. You may choose to include guidelines and/or restrictions to your agent's authority.

(vi) agree or decline to donate your organs or your whole body if you have not already made this decision yourself. This could include donation for transplant, research, and/or education. You should let your agent know whether you are registered as a donor in the First Person Consent registry maintained by the Illinois Secretary of State or whether you have agreed to donate your whole body for medical research and/or education.

(vii) decide what to do with your remains after you have died, if you have not already made plans.

(viii) talk with your other loved ones to help come to a decision (but your designated agent will have the final say over your other loved ones).

Your agent is not automatically responsible for your health care expenses.



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WHOM SHOULD I CHOOSE TO BE MY HEALTH CARE AGENT?

You can pick a family member, but you do not have to. Your agent will have the responsibility to make medical treatment decisions, even if other people close to you might urge a different decision. The selection of your agent should be done carefully, as he or she will have ultimate decision-making authority for your treatment decisions once you are no longer able to voice your preferences. Choose a family member, friend, or other person who:

(i) is at least 18 years old;

(ii) knows you well;

(iii) you trust to do what is best for you and is willing to carry out your wishes, even if he or she may not agree with your wishes;

(iv) would be comfortable talking with and questioning your physicians and other health care providers;

(v) would not be too upset to carry out your wishes if you became very sick; and

(vi) can be there for you when you need it and is willing to accept this important role.

WHAT IF MY AGENT IS NOT AVAILABLE OR IS  
UNWILLING TO MAKE DECISIONS FOR ME?

If the person who is your first choice is unable to carry out this role, then the second agent you chose will make the decisions; if your second agent is not available, then the third agent you chose will make the decisions. The second and third agents are called your successor agents and they function as back-up agents to your first choice agent and may act only one at a time and in the order you list them.

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### WHAT WILL HAPPEN IF I DO NOT CHOOSE A HEALTH CARE AGENT?

If you become unable to make your own health care decisions and have not named an agent in writing, your physician and other health care providers will ask a family member, friend, or guardian to make decisions for you. In Illinois, a law directs which of these individuals will be consulted. In that law, each of these individuals is called a "surrogate".

There are reasons why you may want to name an agent rather than rely on a surrogate:

(i) The person or people listed by this law may not be who you would want to make decisions for you.

(ii) Some family members or friends might not be able or willing to make decisions as you would want them to.

(iii) Family members and friends may disagree with one another about the best decisions.

(iv) Under some circumstances, a surrogate may not be able to make the same kinds of decisions that an agent can make.

### WHAT IF THERE IS NO ONE AVAILABLE WHOM I TRUST TO BE MY AGENT?

In this situation, it is especially important to talk to your physician and other health care providers and create written guidance about what you want or do not want, in case you are ever critically ill and cannot express your own wishes. You can complete a living will. You can also write your wishes down and/or discuss them with your physician or other health care provider and ask him or her to write it down in your chart. You might also want to use written or on-line resources to guide you through this process.

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### WHAT DO I DO WITH THIS FORM ONCE I COMPLETE IT?

Follow these instructions after you have completed the form:

- (i) Sign the form in front of a witness. See the form for a list of who can and cannot witness it.
- (ii) Ask the witness to sign it, too.
- (iii) There is no need to have the form notarized.
- (iv) Give a copy to your agent and to each of your successor agents.
- (v) Give another copy to your physician.
- (vi) Take a copy with you when you go to the hospital.
- (vii) Show it to your family and friends and others who care for you.

### WHAT IF I CHANGE MY MIND?

You may change your mind at any time. If you do, tell someone who is at least 18 years old that you have changed your mind, and/or destroy your document and any copies. If you wish, fill out a new form and make sure everyone you gave the old form to has a copy of the new one, including, but not limited to, your agents and your physicians. If you are concerned you may revoke your power of attorney at a time when you may need it the most, you may initial the box at the end of the form to indicate that you would like a 30-day waiting period after you voice your intent to revoke your power of attorney. This means if your agent is making decisions for you during that time, your agent can continue to make decisions on your behalf. This election is purely optional, and you do not have to choose it. If you do not choose this option, you can change your mind and revoke the power of attorney at any time.

### WHAT IF I DO NOT WANT TO USE THIS FORM?

In the event you do not want to use the Illinois statutory form provided here, any document you complete must be executed by you, designate an agent who is over 18 years of age and not prohibited from serving as your agent, and state the agent's powers, but it need not be witnessed or conform in any other respect to the statutory health care power.

If you have questions about the use of any form, you may want to consult your physician, other health care provider, and/or an attorney.

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MY POWER OF ATTORNEY FOR HEALTH CARE

THIS POWER OF ATTORNEY REVOKES ALL PREVIOUS POWERS OF ATTORNEY FOR HEALTH CARE. (You must sign this form and a witness must also sign it before it is valid)

My name (Print your full name): \_\_\_\_\_

My address: \_\_\_\_\_

I WANT THE FOLLOWING PERSON TO BE MY HEALTH CARE AGENT

(an agent is your personal representative under state and federal law):

(Agent name) \_\_\_\_\_

(Agent address) \_\_\_\_\_

(Agent phone number) \_\_\_\_\_

(Please check box if applicable)

If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as guardian.

PRINT YOUR NAME  
AND ADDRESS

PRINT THE NAME,  
ADDRESS, AND  
PHONE NUMBER OF  
YOUR AGENT

CHECK THIS BOX IF  
YOU WOULD ALSO  
LIKE TO NOMINATE  
YOUR AGENT AS  
THE GUARDIAN OF  
YOUR PERSON, IN  
THE EVENT ONE IS  
TO BE APPOINTED  
FOR YOU

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SUCCESSOR HEALTH CARE AGENT(S) (optional):

If the agent I selected is unable or does not want to make health care decisions for me, then I request the person(s) I name below to be my successor health care agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names):

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(Successor agent #1 name, address and phone number)

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(Successor agent #2 name, address and phone number)

MY AGENT CAN MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING:

- (i) Deciding to accept, withdraw or decline treatment for any physical or mental condition of mine, including life-and-death decisions.
- (ii) Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.
- (iii) Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.
- (iv) Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue or whole body donation, autopsy, cremation, and burial.

The above grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures.

NAME YOUR  
SUCCESSOR AGENTS  
HERE, IF YOU  
CHOOSE TO  
APPOINT ANY

THIS PARAGRAPH  
LISTS THE POWERS  
THAT ARE  
AUTOMATICALLY  
GRANTED TO YOUR  
AGENT

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I AUTHORIZE MY AGENT TO (please check any one box):

- Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. (If no box is checked, then the box above shall be implemented.) OR
- Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. Starting now, for the purpose of assisting me with my health care plans and decisions, my agent shall have complete access to my medical and mental health records, the authority to share them with others as needed, and the complete ability to communicate with my personal physician(s) and other health care providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself. OR
- Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes. Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements.

CHECK ONE OF THE  
THREE BOXES TO  
INDICATE THE  
SITUATION THAT  
BEST DESCRIBES  
WHEN YOU WANT  
YOUR AGENT'S  
POWERS TO TAKE  
EFFECT

**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR  
HEALTH CARE — PAGE 10 OF 12**

SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR  
WISHES (optional):

- The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.
  
- Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

YOU MAY CHECK  
ONE OF THE TWO  
BOXES, OR YOU MAY  
DECLINE TO CHECK  
EITHER

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**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR  
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IF THERE ARE ANY  
POWERS THAT YOU  
DO NOT WANT YOUR  
AGENT TO HAVE, YOU  
SHOULD LIST THEM  
HERE

LIST ANY LIMITS TO  
AGENT'S POWERS

SIGN AND DATE  
HERE

SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically in this form.

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My signature: \_\_\_\_\_

Today's date: \_\_\_\_\_



**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR  
HEALTH CARE — PAGE 12 OF 12**

DELAYED REVOCATION

CHECK ONE OF THESE  
BOXES TO  
DETERMINE WHEN  
YOUR REVOCATION  
OF THIS POWER OF  
ATTORNEY WILL TAKE  
EFFECT

- I elect to delay revocation of this power of attorney for 30 days after I communicate my intent to revoke it.
- I elect for the revocation of this power of attorney to take effect immediately if I communicate my intent to revoke it.

HAVE YOUR WITNESS AGREE TO WHAT IS WRITTEN BELOW, AND THEN  
COMPLETE THE SIGNATURE PORTION:

I am at least 18 years old. (check one of the options below):

- I saw the principal sign this document, or
- the principal told me that the signature or mark on the principal signature line is his or hers.

I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent, or the successor agent(s) by blood, marriage, or adoption. I am not the principal's physician, advanced practice registered nurse, dentist, podiatric physician, optometrist, psychologist, or a relative of one of those individuals. I am not the principal's physician, mental health service provider, or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the health care facility where the principal is a patient or resident.

Witness printed name: \_\_\_\_\_

Witness address: \_\_\_\_\_

Witness signature: \_\_\_\_\_

Today's date: \_\_\_\_\_

YOUR WITNESS  
MUST CHECK ONE  
OF THE TWO  
BOXES AND AGREE  
TO THE  
STATEMENT ABOUT  
RESTRICTIONS ON  
WITNESSES

HAVE YOUR  
WITNESS PRINT  
THEIR NAME AND  
ADDRESS AND SIGN  
HERE

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

**ILLINOIS LIVING WILL— PAGE 1 OF 1**

**DECLARATION**

This declaration is made this \_\_\_\_\_ day of \_\_\_\_\_

(month, year). I, \_\_\_\_\_ being of sound mind, willfully and voluntarily make known my desires that my moment of death shall not be artificially postponed. If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death-delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care. In the absence of my ability to give directions regarding the use of such death-delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Signed \_\_\_\_\_

City, County and State of Residence \_\_\_\_\_

The declarant is personally known to me and I believe him or her to be of sound mind. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he or she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant's signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.

Witness \_\_\_\_\_

Witness \_\_\_\_\_

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

DATE YOUR DOCUMENT HERE

PRINT YOUR NAME HERE

SIGN HERE BY HAND OR ELECTRONICALLY

PRINT YOUR ADDRESS HERE

TWO WITNESSES MUST SIGN BY HAND OR ELECTRONICALLY

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## **You Have Filled Out Your Health Care Directive, Now What?**

1. Your Illinois Statutory Short Form Power of Attorney and Illinois living will are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your agent and alternate agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your Illinois documents.
7. Be aware that your Illinois documents will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician if you are interested in obtaining this form.

**CaringInfo does not distribute these forms.**

## Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Please consider helping us keep this resource free.

Your generous support to the National Hospice Foundation allows us to continue to provide FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services.

**Please show your support for our mission and consider making a tax-deductible gift to the National Hospice Foundation today.**


Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice and palliative care, and providing ongoing professional education and skills development to hospice and palliative care professionals across the nation. To learn more, please visit [www.NationalHospiceFoundation.org](http://www.NationalHospiceFoundation.org)

You may wonder if a gift of \$35, \$50 or \$100 to the National Hospice Foundation would make a difference, but it is only because of the generosity of others like you that these FREE resources are made available.

Please consider supporting our mission by returning a **generous tax-deductible donation**. Every gift makes a difference! Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

**Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.**

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YES! I want to support the important work of the National Hospice Foundation.

<b>\$35</b>	helps us provide webinars to hospice professionals
<b>\$50</b>	helps us provide free advance directives
<b>\$100</b>	helps us maintain our free InfoLine
\$_____	to support the mission of the National Hospice Foundation.

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