Full Name: 

Please print

These directions apply only in situations when I am not able to make or communicate my health care choices directly. Put an X through any sections you are not completing at this time.

1. **Terminal Conditions (Living Will)**

I provide these directions in accordance with the Montana Rights of the Terminally Ill Act. These are my wishes for the kind of treatment I want if I cannot communicate or make my own decisions. These directions are only valid if both of the following two conditions exist:

- I have a terminal condition, and
- In the opinion of my attending physician, I will die in a relatively short time without life sustaining treatment that only prolongs the dying process.

I authorize my Representative, if I have appointed one, to make the decision to provide, withhold, or withdraw any health care treatment.

**General Treatment Directions**

Check the boxes that express your wishes:

- [ ] I provide no directions at this time.
- [ ] I direct my attending physician to withdraw or withhold treatment that merely prolongs the dying process.

I further direct that (check all boxes that apply):

- [ ] Treatment be given to maintain my dignity, keep me comfortable and relieve pain.
- [ ] If I cannot drink, I do not want to receive fluids through a needle or catheter placed in my body unless for comfort.
- [ ] If I cannot eat, I do not want a tube inserted in my nose or mouth, or surgically placed in my stomach to give me food.
- [ ] If I have a serious infection, I do not want antibiotics to prolong my life. Antibiotics may be used to treat a painful infection.

I have attached additional directions regarding medical treatment to this form:

- [ ] Yes  [ ] No
2. Chronic Illness or Serious Disability (Optional)

My chronic illness or disability can complicate an acute illness, but should not be misinterpreted as a terminal condition.

Diagnosis __________________________________________

Consult my physician ________________________________

Name     Phone

Special directions (use additional pages if necessary) _______________________________________

3. Health Care Representative (Power of Attorney for Health Care)

My Representative may make all health care decisions for me as authorized in this document and shall be given access to all my medical records. This appointment applies whether I am expected to recover or not.

I wish to appoint a Representative □ Yes □ No

A. Primary Representative

I appoint ________________________________ as my Representative.

Print Representative’s Full Name

Representative's Address

City       State   Zip

Home Phone     Work Phone

My Representative’s authority is effective when I cannot make health care decisions or communicate my wishes. I may revoke this authority at any time I regain these abilities (unless my attending physician and any necessary experts determine I am not capable of making decisions in my own best interest).

If, for any reason, I should need a guardian of my person designated by a court, I nominate my Representative, or Alternate Representative(s), named below.

B. Alternate Representative(s)

If: 1. I revoke my Representative’s authority; or
    2. My Representative becomes unwilling or unable to act for me; or
    3. My Representative is my spouse and I become legally separated or divorced,
I name the following person(s) as alternates to my Representative in the order listed:

1. ________________________________
   Print Alternate Representative’s Full Name
   Address
   City       State   Zip
   Home Phone     Work Phone

2. ________________________________
   Print Alternate Representative’s Full Name
   Address
   City       State   Zip
   Home Phone     Work Phone
4. **Signing and Witnessing this Advance Directive**

**A. Your Signature**

Ask two people to watch you sign and have them sign below. If you can, it’s best to sign this document in front of a Notary Public.

1. I revoke any prior health care advance directive or directions.
2. This document is intended to be valid in any jurisdiction in which it is presented.
3. A copy of this document is intended to have the same effect as the original.
4. Those who act as I have directed in this document shall be free from legal liability for having followed my directions.
5. If my attending physician is unwilling or unable to comply with my wishes as stated in this document, I direct my care be transferred to a physician who will.

I sign this document on the __________ day of ______________, 20_____________  

______________________________  
Signature  
Print Full Name  

______________________________  
Address  

______________________________  
City  
State  
Zip  

______________________________  
Home Phone  
Work Phone

**B. Ask Your Witnesses to Read and Sign**

I declare that I am over the age of 18 and the person who signed this document has signed these health care advance directives in my presence, and appears to be of sound mind and under no duress, fraud or undue influence.

1. __________________________  2. __________________________  
Signature  Date  Signature  Date  

______________________________  
Printed Name  

______________________________  
Address  

______________________________  
City  State  Zip  

**C. Notarizing This Document**

STATE OF________________________ COUNTY OF________________________  

On this __________ day of ______________, 20_____ , the said known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public within and for the State and County aforesaid, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.

______________________________  
Notary Public for the State of ________________  
Residing at ________________________  
My commission expires _______________________
5. **Special Directions**

A. **Spiritual Preferences**
   
   My religion _________________________ My faith community _________________________
   
   Contact person _________________________ I would like spiritual support □ Yes □ No

B. **Where I Would Like to be When I Die**
   
   □ My home   □ Hospital   □ Nursing home   □ Other _________________________

C. **Donation of Organs at My Death** (check one of the following):
   
   □ I do not wish to donate any of my body, organs, or tissue.
   □ I wish to donate my entire body.
   □ I wish to donate only the following (check all that apply):
     
     □ Any organs, tissues, or body parts   □ Heart   □ Kidneys   □ Lungs
     □ Bone Marrow   □ Eyes   □ Skin   □ Liver   □ Other(s)

D. **After-Death Care** (care of my body, burial, cremation, funeral home preference)

E. **Additional Directions** (use additional pages if necessary) _________________________

   Signature _________________________ Date _________________________

F. **Distributing this Advance Directive**
   
   I plan to deposit this Advance Directive in the Montana End-of-Life Registry: □ Yes □ No
   
   I plan to send copies of this document to the following people or locations:

   **Physician:**
   
   Name
   Address
   City State Zip
   Home Phone Work Phone

   **Family Member:** Relationship ________________
   
   Name
   Address
   City State Zip
   Home Phone Work Phone

   **Hospital:**
   
   Name
   Address
   City State Zip
   Phone

   **Clergy:**
   
   Name
   Address
   City State Zip
   Home Phone Work Phone