4. [ ] I specifically **direct** that my life be prolonged and that I be provided all life-sustaining treatments applicable to my medical condition.

Note: While this directive puts your caregivers in charge of all treatment choices, you can always change your mind. For example, you can start treatments and then discontinue them.

[Initials]

I have other wishes:

_____

_____

_____

_____

_____

5. I would prefer to be cared for and to die:
   [ ] at home
   [✓] in a hospice or palliative care unit

6. If my healthcare provider will not follow this Health Care Directive, I ask that my care be transferred to a healthcare provider who will respect my legal rights.

7. If I am in a hospital or a resident in a healthcare or long-term care facility that will not follow this Advance Directive, I ask that I be transferred to another hospital or care facility that will.

You have the right to be involved in all decisions about your medical care, even those not dealing with terminal conditions or persistent vegetative states. If you have wishes not covered in other parts of this document, please indicate them below:

[Initials] I consent to organ donation

[Initials] I consent to autopsy

[Initials] Provide any medication necessary to alleviate pain and control symptoms, even if such medication might shorten my remaining life

_____

_____

_____

Signature: _____ **Date:** Sept. 15, 2017

Print Name: _____

_____
Your Initials

If you are unable to sign yourself, a substitute may sign on your behalf. The substitute must sign in your presence and in the presence of a witness. The proxy or the proxy's spouse cannot be the substitute or witness.

Name of substitute: _____

Address: _____

_____

Signature: _____Date: _____

Name of witness: Cheri Frazer _____

Address: Cheri's address _____

_____

Signature: [Cheri's signature] _____Date: Sept. 15, 2017

I have distributed this Health Care Directive to the following people. This is a reminder to myself to keep these people informed of any changes. I am aware that outdated or defunct copies of this Health Care Directive may create confusion if left in circulation.

Name and phone number

Daughter's name and cell # _____

Son's name and home number _____

Friend's name and phone number _____

_____

We advise you to regularly review your Health Care Directive. After you do so, and there are no changes to be made, sign it again with the new date in the space below.

Signature _____ Date_____

Signature _____ Date_____

Signature _____ Date_____

Signature _____ Date_____

DC

Your Initials