CATHOLIC HEALTH CARE DIRECTIVE

I, _____, understand this document allows me to do ONE OR BOTH of the following:

PART I (RECOMMENDED): Name another person (called the health care agent) to make health care decisions for me if I am unable to decide or speak for myself. My health care agent must make health care decisions for me based on the instructions I provide in this document (Part II), if any, and the wishes I have made known to him or her. He or she must act in my best interest consistent with the principles of Catholic teaching if I have not made my health care wishes known.

PART II: Give health care instructions to guide others making health care decisions for me. If I have named a health care agent, these instructions are to be used by the agent. These instructions may also be used by my health care providers, others assisting with my health care, and my family, in the event I cannot make decisions for myself.

PART I: APPOINTMENT OF HEALTH CARE AGENT:

THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS FOR ME IF I AM UNABLE TO DECIDE OR SPEAK FOR MYSELF

NOTE: I can change my agent or alternate agent at any time and I do not have to appoint an agent or an alternate agent. If I appoint an agent, I should discuss this health care directive with my agent and give that agent a copy.

When I am unable to decide or speak for myself, I trust and appoint the person named below to make health care decisions for me. This person is called my health care agent.

Name:_____ Relationship: _____

Telephone number:_____ Email:_____

Address of my health care agent:_____

(OPTIONAL) APPOINTMENT OF ALTERNATE HEALTH CARE AGENT:

Name:_____ Relationship: _____

Telephone number:_____ Email:_____

Address of my health care agent:_____

REMINDER: Keep this document with your personal papers in a safe place (not in a safe deposit box). Give signed copies to your doctors, family, close friends, health care agent, and alternate health care agent. Make sure your doctor is willing to follow your wishes. This document should be part of your medical record at your physician's office and at the hospital, home care agency, hospice, or nursing facility where you receive your care.

PART II: HEALTH CARE INSTRUCTIONS

These are instructions for my health care when I am unable to decide or speak for myself. These instructions must be followed (so long as they address my needs).

THESE ARE MY BELIEFS AND VALUES ABOUT MY HEALTH CARE

My Wishes - This is what I want my health care agent—or if I have no health care agent, whoever will make decisions regarding my care— to do if I am unable to make and communicate health care decisions for myself. Most of what I state here is general in nature since I cannot anticipate all the possible circumstances of a future illness. If I have not given specific instructions, then my agent must decide consistent with my wishes and beliefs.

As a Catholic, I believe that God created me for eternal life in union with Him. I understand that my life is a precious gift from God and that this truth should inform all decisions with regards to my health care. I have a duty to preserve my life and to use it for God's glory. Suicide, euthanasia, and acts that intentionally and directly would cause my death by deed or omission, are never morally acceptable. However, I also know that death, being conquered by Christ, need not be resisted by any and every means and that I may refuse any medical treatment that is excessively burdensome or would only prolong my imminent death. Those caring for me should avoid doing anything that is contrary to the moral teaching of the Catholic Church. I ask that decisions be thus made respectful of, and according to, the following principles:

- Medical treatments may be withdrawn or avoided if they do not offer a reasonable hope of benefit to me or are excessively burdensome.
- There should be a presumption in favor of providing me with nutrition and hydration if they are of benefit to me.
- In accord with the teachings of the Church, I have no moral objection to the use of medication or procedures necessary for my comfort, even if they may indirectly and unintentionally shorten my life.
- If my death is imminent, I direct that treatment that will maintain only a precarious and burdensome prolongation of my life should be withdrawn or avoided, unless those responsible for my care judge at that time that there are special and significant reasons why I should continue to receive such treatment.

(Continued)

- If I fall terminally ill, I ask that I be told of this so that I might prepare myself for death, and I ask that efforts be made that I be attended by a Catholic priest and receive the Sacraments of Reconciliation, Anointing, and Eucharist as viaticum.

"My Wishes" in the section above completes my health care directive.

☐ Yes _____ (initials)

☐ No, in addition to the "My Wishes" section, above, I would like you to know these further things about me to help you make decisions about my health care. See attached sheets.

Making an Anatomical Gift (Optional)

So long as it is consistent with Catholic moral teaching, I would like to be an organ donor at the time of my death. I wish the following (initial one statement):

_____ (initial) ☐ Any needed organs and tissue.

_____ (initial) ☐ Only the following organs and tissue: _____

PART III: MAKING THE DOCUMENT LEGAL

This document must be signed by me. It also must either be verified by a notary public (Option 1) OR witnessed by two witnesses (Option 2). It must be dated when it is verified or witnessed. I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

_____ _____ _____

My signature *Date signed* *Date of Birth*

Option 1: Notary Public

In my presence on _____ (date), _____(name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf. I am not named as a health care agent or alternate health care agent in this document.

_____ _____

Signature of Notary *Notary Stamp*

Option 2: Two Witnesses

Two witnesses must sign. Only one of the two witnesses can be a health care provider or an employee of a health care provider giving direct care to me on the day I sign this document.

Witness One:
(i) In my presence on _____(date), _____ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.
(iii) I am not named as a health care agent or an alternate.
(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial this box ☐

I certify that the information in (i) through (iv) is true and correct. _____

Signature of Witness One

Witness Two:
(i) In my presence on _____(date), _____ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(ii) I am at least 18 years of age.
(iii) I am not named as a health care agent or an alternate.
(iv) If I am a health care provider or an employee of a health care provider giving direct care to the person listed above in (A), I must initial this box ☐

I certify that the information in (i) through (iv) is true and correct. _____

Signature of Witness Two