MISSISSIPPI
ADVANCE HEALTH-CARE DIRECTIVE

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator, or employee of a residential long-term health-care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
(b) Select or discharge health-care providers and institutions;
(c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and
(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end and have the form witnessed by one of the two alternative methods listed below. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

INSTRUCTIONS

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR PRIMARY AGENT

(1) **DESIGNATION OF AGENT**: I designate the following individual as my agent to make health-care decisions for me:

_____
(Name of individual you choose as agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

_____
(Name of individual you choose as first alternate agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR SECOND ALTERNATE AGENT

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

_____
(Name of individual you choose as second alternate agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

(2) **AGENT'S AUTHORITY:** My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, **except** as I state here:

_____

_____

_____

_____

_____

(Add additional sheets if needed.)

INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

(3) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:** My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health-care decisions for me takes effect immediately.

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 3, 4 OR 5 THAT DO NOT REFLECT YOUR WISHES

(4) **AGENT'S OBLIGATION**: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) **NOMINATION OF GUARDIAN:** If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill our this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT MEASURES

(6) **END-OF-LIFE DECISIONS:** 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:

[ ] (a) **Choice NOT To Prolong Life**
I do not want my life to be prolonged if (I) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, 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.

INITIAL THE BOX ONLY IF YOU WANT ARTIFICIAL NUTRITION AND HYDRATION REGARDLESS OF YOUR MEDICAL CONDITION

(7) **ARTIFICIAL NUTRITION AND HYDRATION:** Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box [ ], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) **RELIEF FROM PAIN:** Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

ADDITIONAL INSTRUCTIONS (IF ANY)

(9) **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 additional sheets if needed.)

PART 3
PRIMARY PHYSICIAN
(OPTIONAL)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN

(10) I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE PRIMARY PHYSICIAN

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

(11) **EFFECT OF COPY:** A copy of this form has the same effect as the original.

(12) **SIGNATURES:** Sign and date the form here:

SIGN AND DATE THE DOCUMENT

_____ _____
(date) (sign your name)

PRINT YOUR NAME AND ADDRESS

_____ _____
(address) (print your name)

_____
(city) (state)

WITNESSING PROCEDURE

(13) **WITNESSES:** This power of attorney will not be valid for making health-care decisions unless it is either:

(a) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature: or
(b) acknowledged before a notary public in the state.

ALTERNATIVE NO. 1

WITNESS

WITNESS #1

ONE OF YOUR WITNESSES MUST AGREE WITH THIS STATEMENT

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility. I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

HAVE YOUR WITNESS SIGN AND DATE THE DOCUMENT AND THEN PRINT THEIR NAME AND ADDRESS

_____ _____
(date) (signature of witness)

_____ _____
(address) (printed name of witness)

_____
(city) (state)

WITNESS

WITNESS #2

ONE OF YOUR WITNESSES MUST AGREE WITH THIS STATEMENT

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health-care provider, nor an employee of a health-care provider or facility.

HAVE YOUR WITNESS SIGN AND DATE THE DOCUMENT AND THEN PRINT THEIR NAME AND ADDRESS

_____ _____
(date) (signature of witness)

_____ _____
(address) (printed name of witness)

_____
(city) (state)

OR

A NOTARY PUBLIC SHOULD FILL OUT THIS SECTION OF YOUR DOCUMENT

ALTERNATIVE NO. 2

State of _____

County of _____

On this _____ day of _____, in the year _____,

before me, _____ (insert name of notary public)

appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

Notary Seal

_____
(Signature of Notary Public)