DIRECTIONS TO PROTECT AND PRESERVE LIFE

Carry this card with you **AT ALL TIMES**. If I am unconscious, seriously ill, injured or unable to communicate and/or at admission to the hospital contact: ❑ Minister ❑ Priest ❑ Rabbi

_____

Name of Preferred Minister, Priest, or Rabbi

_____

Address, City, State, Zip Code and Telephone Number

I, _____,

(print your full name on blank line)

wish to live the lifespan given by God. I direct that all medical and surgical treatments and care, including nutrition and hydration however administered, be given to protect and preserve my life. **Do not hasten death. Do not shorten life. Do not do an apnea test. Do not take any organ for transplantation or any other purpose.**

_____ _____

Signature of Principal (or legal guardian if under 18) Date

_____ _____

Signature of Witness Date

_____ _____

Signature of Witness Date

* * *

Cut here along line

INSTRUCTIONS TO COMPLETE DIRECTIONS TO PROTECT AND PRESERVE LIFE

Check who you want contacted: Minister, Priest, or Rabbi.
Name a Minister, Priest or Rabbi you prefer to be contacted.
Write address, city, state, zip code and phone number.
I, (then print your name on the blank line).
Designate primary and secondary health care representative serving as agent. These health care representatives serving as agent can speak for you to enforce your life support directions whenever you are not able to communicate.
Provide name, address, city, state, zip code and phone number for each of them.
Sign your name and date.
Have two witnesses observe you sign and date this document.
Neither witness may be related to you or have a claim on your estate.
Neither witness may be a health care provider serving you at this time.
Both witnesses must sign and date.
This card must be kept with you at all times.
Complete Directions To Protect and Preserve Life. Tell your relatives that you have completed Directions to Protect and Preserve Life.

We recommend that you review this with your attorney. We are not attorneys.

I designate my primary health care representative serving as agent to enforce my directions for treatment and care during any period of time in which I am unable to communicate such decisions myself.

_____
Name of Primary Health Care Representative Serving as Agent

_____
Primary Health Care Representative's Address, City, State, Zip Code and Telephone Number

I also designate my secondary health care representative serving as agent if my primary health care representative serving as agent is not immediately available, or is unwilling or unable to communicate decisions regarding my medical treatment and care.

_____
Name of Secondary Health Care Representative Serving as Agent

_____
Secondary Health Care Representative's Address, City, State, Zip Code and Telephone Number

We recommend that these Directions to Protect and Preserve Life be notarized.

I, _____, do solemnly swear that in my presence the foregoing document was signed by _____, on this _____ day of _____, 2013 under penalty of perjury. I state that this document is page two of two.

SUBSCRIBED AND SWORN to before me (Should be sealed here)
this _____day of _____, 2013.

_____
(signature of Notary Public) My commission expires [expiry date].

(These are instructions to complete Directions to Protect and Preserve Life on page 1 of 2)

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