INDIANA
ADVANCE DIRECTIVE

INDIANA HEALTH CARE REPRESENTATIVE:
A Health Care Representative is a person chosen by you to make healthcare decisions, including end-of-life decisions, if you are unable to make your own. It is a good idea to talk with this person about your preferences ahead of time. A doctor will determine if you are unable to make your own decisions.

My name (Full Legal Name – also known as "declarant") Date of Birth (MM/DD/YYYY)

_____ _____

My Health Care Representative can make decisions for me if I cannot make and share my own health care decisions. My Health Care Representative must follow my wishes and values. My values include my ideas about dignity and quality of life. If my Health Care Representative does not know my wishes, my Health Care Representative must act in good faith and make decisions in my best interests. These decisions include but are not limited to:

- Agreeing to medical treatment
- Stopping medical treatment
- Refusing medical treatment
- Arranging comfort care

I want the following person to be my Health Care Representative (HCR):

HCR Name HCR Phone Number

_____ _____

If my primary HCR named above is not able or available to act for me, I want the following person to be my backup Health Care Representative:

Backup HCR Name Backup HCR Phone Number

_____ _____

OPTIONAL STATEMENT OF PREFERENCES:
I would like to provide some additional guidance for my Health Care Representative on my end of life preferences. (Please select only one option below).

☐ The ***quality of my life*** is more important than the length of my life. If I am unable to make my own decisions and my attending physician believes that I will not recover, I do not want treatments to prolong my life or delay my death. Instead, I would want treatment or care to make me comfortable and to relieve me of pain.

☐ ***Staying alive*** is more important to me, no matter how sick I am or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible, in accordance with reasonable medical standards.

☐ I choose to NOT complete this section at this time.

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Declarant Name: _____

REQUIRED SIGNATURES:
By signing this form, I cancel and revoke every health care power of attorney I signed in the past.

_____ _____
Signature (Declarant) Date

_____
Printed Name (Declarant)

This form must be either signed by 2 adult witnesses (below left) or notarized (below right) to be legally valid.

SIGNATURE OF 2 ADULT WITNESSES

Each of the undersigned Witnesses confirms that he or she has received satisfactory proof of the identity of the Declarant and is satisfied that the Declarant is of sound mind and has the capacity to sign the above Advance Directive. **At least one of the undersigned Witnesses is not a spouse or other relative of the Declarant.**

_____
Signature of Adult Witness 1

_____
Printed Name of Adult Witness 1

_____
Date

_____
Signature of Adult Witness 2

_____
Printed Name of Adult Witness 2

_____
Date

_____ Initial here if the Witnesses participated by phone.

This advance directive was created by the Indiana Patient Preferences Coalition and is freely available. See www.INadvancedirectives.org for more information.

NOTARIZATION

STATE OF INDIANA)
) SS:
COUNTY OF _____)

Before me, a Notary Public, personally appeared _____ [*name of signing Declarant*], who acknowledged the execution of the foregoing Advance Directive as his or her voluntary act, and who, having been duly sworn, stated that any representations therein are true.

Witness my hand and Notarial Seal on this _____ day of _____, 20____.

_____
Signature of Notary Public

_____
Notary's Printed Name *(if not on seal)*

_____
Commission Number *(if not on seal)*

_____
Commission Expires *(if not on seal)*

_____
Notary's County of Residence

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