ADVANCE DIRECTIVE

An advance directive is a document that allows a principal to select someone else to make health care decisions if they are not able to for themselves. In addition, it will enable a principal to choose their end-of-life treatment options on whether to prolong their life. Depending on State law, this document must be signed in the presence of a notary public and/or two (2) witnesses.

THIS FORM CONTAINS 2 PARTS (EACH PART IS OPTIONAL):

PART I. MEDICAL POWER OF ATTORNEY

PART II. LIVING WILL

PART I. MEDICAL POWER OF ATTORNEY

A medical power of attorney allows you the right to name someone else to make health care decisions on your behalf.

I choose to: (initial and check) (choose one)

☐ _____ - Have a medical power of attorney.

☐ _____ - Not have a medical power of attorney. Part I of this form is intentionally left blank.

A. PRINCIPAL

I, _____, with a mailing address of _____, City of _____, State of _____, Zip Code: _____ ("Principal") hereby designate:

B. AGENT

_____, with a mailing address of _____, City of _____, State of _____, Zip Code: _____ ("Agent").

AGENT'S TELEPHONE (CELL): (_____) _____-_____

I select the above-named person as my Agent to act in all matters relating to my health care (including my mental health care) and including, without limitation, the power to give or refuse consent to all medical and surgical treatments, hospitalizations, and all related health care. This power of attorney is effective at the point when I am no longer able to communicate my health care wishes. My Agent's decisions under this power of attorney, during any period when I am unable to make and/or communicate my health care decisions or when there is uncertainty as to whether I am dead or alive, are binding on my heirs, devisees, and personal representatives.

C. ALTERNATE AGENT

If my Agent is unable or unwilling to serve or make a decision in a timely manner, I select _____, with a mailing address of _____, City of _____, State of _____, to act as my alternate agent ("Alternate Agent"):

ALTERNATE AGENT'S TELEPHONE (CELL): (_____) _____-_____

I intend for my Agent to receive any and all of my health records and information as if I were the one requesting such information. This release authority applies to any information governed by the Health

Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 1420D, and 45 CFR 160-164.

PART II. LIVING WILL

A living will allows a principal to select end-of-life treatment options in the chance of incapacitation with no viable cure.

I choose to: (initial and check) (choose one)

☐ _____ - Have a living will.

☐ _____ - Not have a living will. Part II of this form is intentionally left blank.

A. PRINCIPAL

I, _____, with a mailing address of _____, City of _____, County of _____, State of _____, with the last four (4) digits of my social security number (SSN) being XXX - XX - _____ ("Principal") desire to advise my doctors and medical providers of my wishes for my health care in the event I am not able to communicate my wishes.

B. LIFE SUPPORT

I desire that my doctor make a concerted effort to return me to an acceptable quality of life using then available treatments and therapies. However, if my quality of life becomes unacceptable as I have defined below, and my doctors have determined that my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

An unacceptable quality of life means (initial and check all that apply):

☐ _____ - Chronic coma or persistent vegetative state

☐ _____ - No longer able to communicate my needs

☐ _____ - No longer able to recognize family or friends

☐ _____ - Total dependence on others for daily care

☐ _____ - Other: _____.

(initial and check) (choose one)

☐ _____ - Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV).

☐ _____ - If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

C. CERTAIN LIFE-SUSTAINING TREATMENT

Some people do not wish to have certain life-sustaining treatments under any circumstance, even if recovery is a possibility. Check the treatments below, if any, that you do not wish to have under any circumstances:

(initial and check) (choose one)

☐ _____ - Cardiopulmonary Resuscitation (CPR)

☐ _____ - Ventilation (breathing machine)

☐ _____ - Feeding tube

☐ _____ - Dialysis

☐ _____ - Other: _____.

D. END OF LIFE WISHES

(hospice care, funeral arrangements, etc.):

When I am near death, it is important to me that: _____

_____

I have signed this document on this _____ day of _____, 20_____.

Principal's Signature: _____

Print Name: _____

Depending on your State's laws, you either two (2) witnesses and/or notary public may be required for signing this form.

WITNESSES / NOTARY ACKNOWLEDGMENT.

On the date set forth above, I hereby state as follows:

The above-named person is personally known to me, and I believe him/her to be of sound mind and to have voluntarily executed this document. I am at least 18 years old, not related to him/her by blood, marriage or adoption, and I am not an Agent or successor Agent named in this document. To my knowledge, I am not a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

WITNESS 1

Signature: _____ Date: _____

Print Name: _____

WITNESS 2

Signature: _____ Date: _____

Print Name: _____

NOTARY ACKNOWLEDGMENT

State of _____ }

County of _____ }

Signed and sworn to me on the _____ day of _____, 20_____.

I, the undersigned authority in and for said County in said State, hereby certify that the Principal, _____, whose name is signed above in this living will, and who is known to me, acknowledged before me on this day that, being informed of the contents of the said document, (s)he executed the same voluntarily on the day the same bears date.

Given under my hand this _____ day of _____, 20_____.

Notary Public Signature: _____

Printed Name: _____

My commission expires: _____

(Notary Seal)

ARSENK ID, CORP.