

Protective Medical Decisions Declaration

Name_____

Address_____

City/State/Zip Code_____

The following statements serve as a set of specific directives expressing my values in general, and also regarding certain specific medical interventions. It is intended to guide anyone making medical decisions for me when I am unable to participate in the decision-making. I direct that this values history and the accompanying *Instructions for My Medical Care* become part of my permanent medical record. A check in the box next to a statement (and my initials where necessary) indicate it is in accord with my beliefs and wishes.

Values History

- God, as revealed in the Bible, is sovereign and He alone determines the length of our lives.
- The Bible is my final authority and all decisions related to my life must be consistent with its teachings.
- For me, physical death is only a transition from this temporal, earthly existence into an eternal existence in the presence of God, therefore it is not paramount that my life be extended at all cost.
- Although life can be burdensome in many ways, earthly existence remains intrinsically good. Therefore, remaining alive is never rightly regarded as being a burden in itself, and deliberately ending human life is never rightly regarded as providing a benefit.
- Although the elimination of pain and/or suffering is one legitimate goal of medicine, intentionally hastening the death of a person as a means of obtaining relief from pain and or suffering is not a legitimate medical practice. Therefore, I reject assisted suicide and euthanasia as immoral and illegitimate means of addressing pain and/or suffering.
- As a person possessing intrinsic dignity, worth and value, whether conscious or unconscious, I have a right not to be killed by those whose responsibility it is to provide care to me.

Instructions for My Medical Care

- Although I do not wish to suffer great pain, I specifically do not authorize anyone to carry out any action with the purpose of ending my life. However, if I am diagnosed as terminally ill, I do accept the administration of sufficient medication and other measures to make me as comfortable as possible, even when increased dosages of medication may inadvertently hasten my death.

- Since food and water are basic substances for physical existence, I authorize my attending physician to withhold or withdraw artificially or technologically supplied nutrition and hydration, subject to the conditions indicated below. My agreement with this statement is attested by the mark in the box above, followed by my initials, and is subject to the conditions below, attested in the same manner:
 - When my death is expected within a matter of hours or days;
 - When the intent is not to hasten my death, but to contribute to my physical comfort;
 - When my physical condition has deteriorated to the point where I am no longer able to assimilate hydration and nutrition.
 - When my attending physician, and one other independent physician who has personally examined me, determines to the highest degree of medical certainty possible, that nutrition or hydration will not or will no longer be of any physical benefit.

- Upon my death my body should be treated with respect.

- Under the conditions listed below I wish to undergo cardiopulmonary resuscitation:
 - Once
 - Twice
 - As many times as necessary to restore heart and lung functions
 - Never
 - When there is reason to believe resuscitation will restore heart and lung functions.
 - Other (explain) _____

- Under the conditions listed below I want to be placed on a ventilator:
 - In all circumstances.
 - For a trial period to determine effectiveness using reasonable medical judgment.
 - Under no circumstances. Why? _____

I desire medications and therapies used for the treatment of my illness continued provided such medications and therapies continue to be physically beneficial.

I authorize the use of nasogastric____, gastrostomy____ or other methods of technology-assisted feeding to facilitate my medical and/or comfort care.

- I authorize being placed on a dialysis machine under the following conditions:
 - Under all circumstances when such treatment would be beneficial to my physical condition.
 - For a trial period as recommended by my attending physician to determine effectiveness using reasonable medical judgment.
 - Under no circumstances. Why? _____

I want to be admitted to the Intensive Care Unit (ICU) under the following conditions:

- When ICU admission conforms to the standards of care for my condition.
- When the seriousness of my condition warrants ICU care and there is reasonable hope that ICU care will result in my leaving the hospital alive.

If I have been diagnosed with a terminal condition, I do not wish to be resuscitated by emergency personnel (911 emergency medical technicians) if I am found un-

conscious, or if I am not breathing or in cardiac arrest.*

*A terminal condition is defined as an irreversible, incurable condition or illness which, according to the highest possible degree of medical certainty, will cause death within a period of six months, with or without treatment. This diagnosis must be confirmed in writing by two independent physicians that have personally examined me and my medical records.

- If I am pregnant at a time when I am unable to make my own medical decisions, all reasonable efforts must be undertaken to maximize survival for me and my unborn child.

Remarks, clarifications, etc.:

Signature of Declarant _____ Date _____

Primary Advocate (as named in Durable Power of Attorney for Health Care)

Name _____

Address _____

City _____ State _____ Zip Code _____

Home Telephone (____) _____ Work Telephone (____) _____

Secondary Advocate (as named in Durable Power of Attorney for Health Care)

Name _____

Address _____

City _____ State _____ Zip Code _____

Home Telephone (____) _____ Work Telephone (____) _____

Witnesses

I declare that the person who signed this document appears to be of sound mind and is personally known to me. I further declare that he/she signed or acknowledged this Protective Medical Decisions Declaration in my presence, and that he/she appears to understand the document and to be under no duress, fraud or undue influence. I am not the person named as an advocate by this person, nor am I the signer's health care provider or an employee of the signer's health care provider. I declare that I am at least 18-years of age and am a legal resident of the United States of America. I declare that I am not related to the declarant by blood, marriage or adoption and, to the best of my knowledge, I am not entitled to any part of his/her estate under a will now existing or by operation of law.

First Witness' Signature _____ Date _____

Print Name _____

Address _____ Phone _____

Second Witness' Signature _____ Date _____

Print Name _____

Address _____ Phone _____

Notarization (may be required in some states)

Declarant's Signature _____ Date _____

Address _____

State of _____ County of _____. Subscribed, sworn to, and acknowledged before me by _____, on this _____ day of _____, 20____.

Notary Public _____

My commission expires _____

Instructions for Signed Documents

1. Keep a signed original of this document in a safe, secure place with your Durable Power of Attorney for Health Care and other important papers.
2. This Protective Medical Decisions Declaration is intended to help you clarify your wishes as a person who upholds the sanctity of human life and the sovereignty of God over matters of life and death. It does not replace a Durable Power of Attorney for Health Care. Durable Power of Attorney for Health Care forms for all fifty states are available for download free of charge from National Right to Life at <http://www.nrlc.org/euthanasia/willtolive/StatesList.html>.
3. Give signed originals to your advocate(s), physician, family, pastor and a close friend.
4. Discuss this document with your primary care physician, pastor, family and any other people who would be affected by it.
5. Request that this document become part of your medical record.
6. Notify all holders of your Protective Medical Decisions Declaration if you amend or revoke your instructions.

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