DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Statutory Advance Directive

For

Georgia Residents

Standard State Statutory
Advance Directive for
Health Care Choices

~ *Lifecare Directives* ~

Statutory Advance Directive

For

Georgia Residents

Standard State Statutory Advance Directive for Health Care Choices

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive
For Georgia Residents

____________________________ _____________________

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes,*
and to have these wishes followed ~~

The Georgia state legislature has designed a statutory Living Will as well as a Power of Attorney for Health Care for use by the public. Together, they may be called an "advance directive." As these documents were designed by the state legislature, each is in full compliance with all applicable statutes and laws.

There is an introduction that summarizes the scope and purpose of each document, as well as providing directions for its completion. Read them carefully to ensure that your Advance Directive is fully and properly filled out.

***Understanding Your Directive*:**

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to speak due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want, if you cannot speak for yourself.

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

It is recommended that you ***first read through the entire directive before you actually complete it****. You may even want to create an answer worksheet. This can allow you to more easily make revisions as you consider and discuss your early wishes with others. In this way you can avoid making any changes or alterations to the final document.*

If there is anything in this Directive you do not understand, you should read the Guidebook, ask your physician or a health care professional, or call an attorney for help.

SECTION I:

LIVING WILL DECLARATION

And Personal Instructions

(Title 31:Ch. 32: §31-32-1 to §31-32-12)

1. INTRODUCTION: *The laws of Georgia explicitly allow a living will declaration to provide authoritative and binding guidance in situations of terminal conditions, and comatose or persistent vegetative states. A terminal condition is defined as an "incurable condition caused by disease, illness, or injury which, regardless of the application of life-sustaining procedures, would produce death"(§31-32-2). Coma is defined as "a profound state of unconsciousness...for which...there exists no reasonable expectation of regaining consciousness." A persistent vegetative state is described as "a state of severe mental impairment in which only involuntary bodily functions are present, and for which there exists no reasonable expectation of regaining significant cognitive function"(§31-32-2). Each condition must be diagnosed by an attending physician and a second physician who both certify the condition(s) in writing (§31-32-2).*

   Life-sustaining treatment is defined as: "any medical procedures or interventions, which...would serve only to prolong the dying process and where...death will occur without such procedures or interventions." It is further noted that the term "life-sustaining procedures" may either include or exclude (at your direction) the delivery of artificial nourishment and hydration (i.e., tube feeding), "but shall not include the administration of medication to alleviate pain or the performance of any medical procedure deemed necessary to alleviate pain." More simply put, you will not be left in untreated pain if you elect to forego any manner of 'life-sustaining' treatment.

LIVING WILL

2. Living will made this ________ day of _________________________________ , 20______.

3. I, ____, being of sound mind, do willfully and voluntarily make known my desire that my life shall not be prolonged under the circumstances set forth below and do declare:

4. If at any time I should (*initial each option desired*):

(_____) have a terminal condition,

(_____) be in a coma with no reasonable expectation of regaining consciousness,

(_____) be in a persistent vegetative state with no reasonable expectation of regaining significant cognitive function, as defined in and established in accordance with the procedures set forth in paragraphs (2), (9), and (13) of Code Section 31-32-2 of the Official Code of Georgia Annotated, then:

5. I direct that the application of life-sustaining procedures (*initial only one*):

(_____) including nourishment and hydration, or

(_____) including nourishment but not hydration, or

(_____) excluding both nourishment and hydration,

~~ be withheld or withdrawn and that I be permitted to die;

6. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this living will shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal;
7. I understand that I may revoke this living will at any time;
8. I understand the full import of this living will, and I am at least 18 years of age and am emotionally and mentally competent to make this living will; and
9. If I am a female and I have been diagnosed as pregnant, this living will shall have no force and effect unless the fetus is not viable and I indicate by initialing after this sentence that I want this living will to be carried out. _________(*initials*)

(*Do not sign below until in the presence of two qualified witnesses*)

10. Signed: ________________________________ Date: ______________________

City: __________________________________ County: ____________________

Statement of Witnesses

11. I hereby witness this living will and attest that: (1) The declarant is personally known to me and I believe the declarant to be at least 18 years of age and of sound mind; (2) I am at least 18 years of age; (3) To the best of my knowledge, at the time of the execution of this living will, I: (A) Am not related to the declarant by blood or marriage; (B) Would not be entitled to any portion of the declarant's estate by any will or by operation of law under the rules of descent and distribution of this state; (C) Am not the attending physician of declarant or an employee of the attending physician or an employee of the hospital or skilled nursing facility in which declarant is a patient; (D) Am not directly financially responsible for the declarant's medical care; and (E) I have no present claim against any portion of the estate of the declarant; (4) Declarant has signed this document in my presence as above instructed, on the date above first shown.

12. 1st Witness: ____
(Signature)

________________________________ ____________________
(Name Printed) (Date)

____
(Residence Address)

13. 2nd Witness: ____
(Signature)

________________________________ ____________________
(Name Printed) (Date)

____
(Residence Address)

(*An attending physician is required as an additional witness when a health care agency is signed in a hospital or skilled nursing facility*):

Statement of Attending Physician

14. I hereby witness this health care agency and attest that I believe the principal to be of sound mind and to have made this health care agency willingly and voluntarily.

Signature: ___________________________________ Date: ______________________

(*Check one of the following*)

_____ Medical director of skilled nursing facility, or
_____ Staff physician not participating in care of the patient, or
_____ Chief of the hospital medical staff, or
_____ Staff physician or hospital designee not participating in care of the patient.

SECTION II:
GEORGIA STATUTORY SHORT FORM
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(Pursuant to Title 31:Ch. 36: §31-36-1 to §31-36-13)

NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (*YOUR AGENT*) BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU, INCLUDING:

- POWER TO REQUIRE, CONSENT TO, OR WITHDRAW ANY TYPE OF PERSONAL CARE OR MEDICAL TREATMENT FOR ANY PHYSICAL OR MENTAL CONDITION AND
- TO ADMIT YOU TO OR DISCHARGE YOU FROM ANY HOSPITAL, HOME, OR OTHER INSTITUTION;
- BUT NOT INCLUDING PSYCHOSURGERY, STERILIZATION, OR INVOLUNTARY HOSPITALIZATION OR TREATMENT COVERED BY TITLE 37 OF THE OFFICIAL CODE OF GEORGIA ANNOTATED.

THIS FORM DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS; BUT, WHEN A POWER IS EXERCISED, YOUR AGENT WILL HAVE TO USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS FORM. A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THE AGENT IS NOT ACTING PROPERLY. YOU MAY NAME CO-AGENTS AND SUCCESSOR AGENTS UNDER THIS FORM, BUT YOU MAY NOT NAME A HEALTH CARE PROVIDER WHO MAY BE DIRECTLY OR INDIRECTLY INVOLVED IN RENDERING HEALTH CARE TO YOU UNDER THIS POWER.

UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THIS POWER IN THE MANNER PROVIDED BELOW, OR UNTIL YOU REVOKE THIS POWER OR A COURT ACTING ON YOUR BEHALF TERMINATES IT, YOUR AGENT MAY EXERCISE THE POWERS GIVEN IN THIS POWER THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME DISABLED, INCAPACITATED, OR INCOMPETENT.

THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO REVOKE THOSE POWERS, AND THE PENALTIES FOR VIOLATING THE LAW ARE EXPLAINED MORE FULLY IN CODE SECTIONS §31-36-6, §31-36-9, AND §31-36-10 OF THE GEORGIA "*DURABLE POWER OF ATTORNEY FOR HEALTH CARE ACT*" OF WHICH THIS FORM IS A PART. THAT ACT EXPRESSLY PERMITS THE USE OF ANY DIFFERENT FORM OF POWER OF ATTORNEY YOU MAY DESIRE. IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

DURABLE POWER OF ATTORNEY

15. Made this _________ day of ______________________________________, 20_______.

16. Be it Known that I,
    Full Legal Name: ____
    Date of Birth: ____
    Street Address: ____
    City: ______________________________ County: ___________________________
    State: ______________________________ Zip Code: _________________________

17. Do hereby appoint,

Name of Agent: ____

Address: ____

Telephone: Home:________________________ Work:_________________________

Cell Phone or Pager: ______________________ E-mail: ________________________

~~ as my attorney in fact (my agent) to act for me and in my name in any way I could act in person, to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and health care and to require, withhold, or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any part or all of my body for medical purposes, authorize an autopsy of my body, and direct the disposition of my remains.

THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF NOURISHMENT AND FLUIDS AND OTHER LIFE- SUSTAINING OR DEATH-DELAYING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT'S POWERS OR PRESCRIBE SPECIAL RULES TO LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY, OR DISPOSE OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.

Rules and Limitations:

18. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (*here you may include any specific limitations you deem appropriate, such as your own definition of when life-sustaining or death-delaying measures should be withheld; a direction to continue nourishment and fluids or other life-sustaining or death-delaying treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electroconvulsive therapy, or amputation*):

____
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Life-Sustaining Treatment Decisions:

19. THE SUBJECT OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT, BUT **DO NOT INITIAL MORE THAN ONE**:

20. (_____) I do not want my life to be prolonged nor do I want life-sustaining or death-delaying treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining or death-delaying treatment.

21. (_____) I want my life to be prolonged and I want life-sustaining or death-delaying treatment to be provided or continued unless I am in a coma, including a persistent vegetative state, which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered such an irreversible coma, I want life-sustaining or death-delaying treatment to be withheld or discontinued.

22. (_____) I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures.

Revocation, Authorization, Limitations:

23. THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU AT ANY TIME AND IN ANY MANNER WHILE YOU ARE ABLE TO DO SO. IN THE ABSENCE OF AN AMENDMENT OR REVOCATION, THE AUTHORITY GRANTED IN THIS POWER OF ATTORNEY WILL BECOME EFFECTIVE AT THE TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH AND WILL CONTINUE BEYOND YOUR DEATH IF ANATOMICAL GIFT, AUTOPSY, OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:

24. (_____) This power of attorney shall become effective on ______________________ (*above, insert a future date or event during your lifetime, such as court determination of your disability, incapacity, or incompetency, when you want this power to first take effect*).

25. (_____) This power of attorney shall terminate on ____________________________ (*above, insert a future date or event, such as court determination of your disability, incapacity, or incompetency, when you want this power to terminate prior to your death*).

IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND ADDRESSES OF SUCH SUCCESSORS IN THE FOLLOWING PARAGRAPH:

Successor Agents (*optional*):

26. If any agent named by me shall die, become legally disabled, incapacitated, or incompetent, or resign, refuse to act, or be unavailable, I name the following (each to act successively in the order named) as successors to such agent:

27. Name of Alternate #1:____
Address: ____
Telephone: Home:______________________ Work:_______________________
Cell Phone or Pager: ____________________ E-mail: _____________________

28. Name of Alternate #2: ____
Address: ____
Telephone: Home:______________________ Work:_______________________
Cell Phone or Pager: ____________________ E-mail: _____________________

IF YOU WISH TO NAME A GUARDIAN OF YOUR PERSON IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED, YOU MAY, BUT ARE NOT REQUIRED TO, DO SO BY INSERTING THE NAME OF SUCH GUARDIAN IN THE FOLLOWING PARAGRAPH. THE COURT WILL APPOINT THE PERSON NOMINATED BY YOU IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. YOU MAY, BUT ARE NOT REQUIRED TO, NOMINATE AS YOUR GUARDIAN THE SAME PERSON NAMED IN THIS FORM AS YOUR AGENT.

29. If a guardian of my person is to be appointed, I nominate the following to serve as such guardian:
Name:____
Address: ____
Telephone: Home:______________________ Work:_______________________
Cell Phone or Pager: ____________________ E-mail: _____________________

30. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed:____________________________________ Date: ________________________

At: (City) __________________________________ (State) _______________________

Statement of Witnesses

31. The principal has had an opportunity to read the above form and has signed the above form in our presence. We, the undersigned, each being over 18 years of age, witness the principal's signature at the request and in the presence of the principal, and in the presence of each other, on the day and year above set out.

32. 1st Witness: ______________________________
(Signature)

______________________ ______________
(Name Printed) (Date)

____
(Residence Address)

33. 2nd Witness: ______________________________
(Signature)

______________________ ______________
(Name Printed) (Date)

____
(Residence Address)

(*An attending physician is required as an additional witness when a health care agency is signed in a hospital or skilled nursing facility*):

Statement of Attending Physician

34. I hereby witness this health care agency and attest that I believe the principal to be of sound mind and to have made this health care agency willingly and voluntarily.

35. Signature: ______________________ Date: ______________
(Attending Physician)

Name/Title Printed: ______________________________

Address: ______________________________

Telephone: ______________________________

YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.

36. I certify that the signature of my agent Specimen signatures of and successor(s) is agent and successor(s) correct.

______________________	______________________
(Agent)	(Principal)
______________________	______________________
(Successor agent)	(Principal)
______________________	______________________
(Successor agent)	(Principal)