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
Illinois Residents

Standard State Statutory
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive For Illinois 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 Illinois 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 Illinois state legislature has designed both a Living Will and a Power of Attorney for Health Care for use by the public. As statutory documents designed by state government, each is in full compliance with all applicable statutes and laws.

By completing your Lifecare Directive, you can have the peace of mind that some of your wishes are known and can be followed. It is also a meaningful gift to those you love. Your completed directive will help ensure that you r loved ones will have to make fewer difficult choices for you without having an understanding of what you would want done.

***Understanding Your Directive*:**

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 Declaration 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.

To complete each document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

SECTION I:

ILLINOIS LIVING WILL

DECLARATION

(*Pursuant to Illinois Statute §755 35/3*)

DECLARATION

This declaration is made this_____day of _____, 20_____.
I, _____, being of sound mind, willfully and voluntarily make known my desires that my moment of death shall not be artificially postponed.

If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me, and has determined that my death is imminent except for death delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.

Other Additional Directions: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

In the absence of my ability to give directions regarding the use of such death delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Signed: _____

Date: _____

Address: _____

Statement of Witnesses

The declarant is personally known to me and I believe him or her to be of sound mind. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he or she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant's signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.

Witness: _____

Printed Name: _____

Address: _____

Witness: _____

Printed Name: _____

Address: _____

SECTION II:
ILLINOIS STATUTORY SHORT FORM
POWER OF ATTORNEY FOR HEALTH CARE
(*Pursuant to Illinois Statute §755 45/4-10*)

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. THIS FORM DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS; BUT WHEN POWERS ARE EXERCISED, YOUR AGENT WILL HAVE TO USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS FORM AND KEEP A RECORD OF RECEIPTS, DISBURSEMENTS AND SIGNIFICANT ACTIONS TAKEN AS AGENT. A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THE AGENT IS NOT ACTING PROPERLY. YOU MAY NAME SUCCESSOR AGENTS UNDER THIS FORM BUT NOT CO-AGENTS, AND NO HEALTH CARE PROVIDER MAY BE NAMED. UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THIS POWER IN THE MANNER PROVIDED BELOW, UNTIL YOU REVOKE THIS POWER OR A COURT ACTING ON YOUR BEHALF TERMINATES IT, YOUR AGENT MAY EXERCISE THE POWERS GIVEN HERE THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME DISABLED. THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO REVOKE THOSE POWERS AND THE PENALTIES FOR VIOLATING THE LAW ARE EXPLAINED MORE FULLY IN SECTIONS 4-5, 4-6, 4-9 AND 4-10(b) OF THE ILLINOIS "POWERS OF ATTORNEY FOR HEALTH CARE LAW" OF WHICH THIS FORM IS A PART (SEE THE BACK OF THIS FORM). THAT LAW 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.

POWER OF ATTORNEY made this_____day of _____, 20_____.

1. ***Be It Known that I***,

Full Legal Name: _____
Date of Birth: _____
Street Address: _____
City: _____ County: _____
State: _____ Zip Code: _____

~~ 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 authorize an autopsy and direct the disposition of my remains. Effective upon my death, my agent also has the full power to make an anatomical gift of the following:

(*initial only <u>one</u>*)

_____ Any organs, tissues, or eyes suitable for transplantation or used for research or education.

OR,

_____ The following specific organs and/or tissues: _____

_____

_____

(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 FOOD AND WATER AND OTHER LIFE-SUSTAINING 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 OR LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY OR DISPOSE OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.)

2. The powers granted above shall <u>not</u> 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 measures should be withheld; a direction to continue food and fluids or life-sustaining 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, electro-convulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc*.):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(THE SUBJECT OF LIFE-SUSTAINING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING 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):

_____ I do not want my life to be prolonged nor do I want life-sustaining 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 treatment.

OR,

_____ I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am in a coma 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 irreversible coma, I want life-sustaining treatment to be withheld or discontinued.

OR,

_____ 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.

(THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU IN THE MANNER PROVIDED IN SECTION 4-6 OF THE ILLINOIS "POWERS OF ATTORNEY FOR HEALTH CARE LAW" (SEE THE BACK OF THIS FORM). ABSENT 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 BEYOND 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:)

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

4. This power of attorney shall terminate on (*insert a future date or event, such as court determination of your disability, 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.)

5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent, or be unavailable, I name the following (*each to act alone and successively, in the order named*) as successors to such agent:

Name of Alternate #1:_____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

Name of Alternate #2: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

~~ For purposes of this paragraph 5, a person shall be considered to be incompetent if and while the person is a minor or an adjudicated incompetent or disabled person or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.

(IF YOU WISH TO NAME YOUR AGENT AS 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 RETAINING THE FOLLOWING PARAGRAPH. THE COURT WILL APPOINT YOUR AGENT IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. STRIKE OUT PARAGRAPH 6 IF YOU DO NOT WANT YOUR AGENT TO ACT AS GUARDIAN.)[

6. If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

7. 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 Witness

The principal has had an opportunity to read the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence.

Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

(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.)

Specimen signatures of
agent (and successors).

_____
(agent)

_____
(successor agent)

_____
(successor agent)

I certify that the signatures of my
agent (and successors) are correct.

_____
(principal)

_____
(principal)

_____
(principal)