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:

Lifecare Directives, LLC
5348 Vegas Drive
Las Vegas, NV 89108
www.lifecaredirectives.com
Toll Free: (877) 559-0527

~ Lifecare Directives ~

Statutory Advance Directive

For

Maryland Residents

Standard State Statutory
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For

Maryland 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 Maryland 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 Maryland state legislature has designed a combined Power of Attorney for Health Care and Living Will ("Health Care for use by the public. As this document was designed by your state government, it is in full compliance with all applicable statutes and laws.

There is an introduction to each section of the directive, which summarizes the scope and purpose, as well as providing directions for completion. Read each carefully to ensure that you fully understand your Advance Directive, and that it 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.

You can **revoke** (cancel) this directive at ***any*** time by: 1) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or 2) by completing a Notice of Revocation; or 3) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or 4) *by simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *only at the time of first completion*. Any scope-of-authority changes needed *after* your directive has been witnessed must be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize the statement of the limitations and exclusions as you have described them. Remember, unless

you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the 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 statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, only partial completion 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 the 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:
Advance Medical Directive
Health Care Instructions
(*Optional Form*)

INTRODUCTION: *The original Maryland Living Will was designed specifically to refuse medical treatment in the event an individual was ever "diagnosed [with]…a terminal condition" or left in a "persistent vegetative state" (§5-601). This document was found to be too limited in its scope by the public. Subsequent legislation provided for this "Advance Directive" document in which individuals can write out further "health care instructions." As noted by the Maryland Office of the Attorney General, these revised statutes allow "broader health care instructions" including those "that deal with situations other than life-sustaining procedures" (see "Advance Directives, a Guide to Maryland Law," Office of the Attorney General).*

(*Cross through if you do not want to complete this portion of the form. If you do want to complete this portion of the form, initial those statements you want to be included in the document and cross through those statements that do not apply*.)

Statement of Directive Intent

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions as set forth below.

(1) If my death from a **terminal condition** is imminent and even if life-sustaining procedures are used there is no reasonable expectation of my recovery ~~

(*Initial all those that apply*.)

_____ I direct that my life **not** be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life **not** be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

2) If I am in a **persistent vegetative state**, that is, if I am not conscious and am not aware of my environment or able to interact with others, and there is no reasonable expectation of my recovery ~~

(*Initial all those that apply*.)

_____ I direct that my life **not** be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life **not** be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

(3) If I have an **end-stage condition**, that is a condition caused by injury, disease, or illness, as a result of which I have suffered severe and permanent deterioration **indicated by incompetency *and* complete physical dependency** and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective ~~

(*Initial all those that apply*.)

_____ I direct that my life **not** be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

_____ I direct that my life **not** be extended by life-sustaining procedures, except that if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

(4) I direct that no matter what my condition, medication **not be given** to me to relieve pain and suffering, if it would shorten my remaining life.

(5) I direct that no matter what my condition, I be **given all available medical treatment** in accordance with accepted health care standards.

(6) If I am **pregnant**, my decision concerning life-sustaining procedures shall be modified as follows: _____
_____
_____
_____

(7) Upon my death, I wish to **donate**:

_____ Any needed organs, tissues, or eyes.

_____ Only the following organs, tissues, or eyes:

_____

_____

_____

I **authorize** the use of my organs, tissues, or eyes:

_____ For transplantation
_____ For therapy
_____ For research
_____ For medical education
_____ For any purpose authorized by law.

I understand that before any vital organ, tissue, or eye may be removed for transplantation, I must be pronounced dead. After death, I direct that all support measures be continued to **maintain the viability** for transplantation of my organs, tissues, and eyes until organ, tissue, and/or eye recovery has been completed.

I understand that **my estate will not be charged** for any costs associated with my decision to donate my organs, tissues, or eyes or the actual disposition of my organs, tissues, or eyes.

(8) I also direct (*in the following space, indicate any other instructions regarding receipt or non-receipt of any health care*)

_____
_____
_____
_____
_____
_____
_____

Signature of Principal / Grantor

By signing below, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand the purpose and effect of this document.

Signed:_____ Date: _____

At: (City) _____ (State) _____

Statement and Signatures of Witnesses

The declarant signed or acknowledged signing the foregoing advance directive in my presence and based upon personal observation appears to be a competent individual.

1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

SECTION II:

Appointment of Health Care Agent

(*Optional Form*)

INTRODUCTION: *This section lets you name a person to make health care and other related decisions for you, if you cannot make them for yourself. The person must be at least 18 years of age. Cross through this section of the directive if you do not want to appoint a health care agent to make health care decisions for you. If you do want to appoint an agent, you may still cross through any items in the form that you do not want to apply. Unless you indicate otherwise, the powers which you may grant through this document include the authority to make health care decisions, including life-sustaining treatment decisions, as well as other authorities regarding related affairs. If you have questions, you should seek further counsel and advice*.

(*Cross through this section if you do not want to appoint a health care agent to make health care decisions for you. If you do want to appoint an agent, you may cross through any items in the form that you do not want to apply*.)

(1) Be it known that I,

Full Legal Name: _____

Date of Birth: _____

Street Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

~~ appoint the following individual as my agent to make health care decisions for me:

Name of Agent: _____

Address: _____

Telephone: Home:_____ Work:_____

Cell Phone or Pager: _____ E-mail: _____

~~ (*Optional*): If this agent is unavailable or is unable or unwilling to act as my agent, then I appoint the following person as successor to act in this capacity:

Name of Alternate #1:_____

Address: _____

Telephone: Home:_____ Work:_____

Cell Phone or Pager: _____ E-mail: _____

(2) My agent (and alternate successor) has full power and authority to make health care decisions for me, including the power to:

a. Request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and consent to disclosure of this information;

b. Employ and discharge my health care providers;

c. Authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult home, or other medical care facility; and

d. Consent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life-sustaining procedures.

(3) The authority of my agent is subject to the following provisions and limitations:

_____

_____

_____

_____

_____

_____

_____

_____

(4) My agent's authority becomes operative (*initial the option that applies*):

_____ When my attending physician and a second physician determine that I am incapable of making an informed decision regarding my health care;

OR,

_____ When this document is signed.

(5) My agent is to make health care decisions for me based on the health care instructions I give in this document and on my wishes as otherwise known to my agent. If my wishes are unknown or unclear, my agent is to make health care decisions for me in accordance with my best interest, to be determined by my agent after considering the benefits, burdens, and risks that might result from a given treatment or course of treatment, or from the withholding or withdrawal of a treatment or course of treatment.

(6) My agent shall not be liable for the costs of care based solely on this authorization.

Signature of Principal / Grantor

By signing below, I indicate that I am emotionally and mentally competent to make this appointment of a health care agent and that I understand its purpose and effect.

Signed:_____ Date: _____

At: (City) _____ (State) _____

Statement and Signature of Witnesses

The declarant signed or acknowledged signing this appointment of a health care agent in my presence and based upon my personal observation appears to be a competent individual.

1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)