

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 professionals 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
Pennsylvania Residents*



*Standard State Statutory
Advance Directive for
Health Care Choices*

~ Lifecare Directives ~



*Statutory
Advance Directive
For
Pennsylvania 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 warranted 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 Pennsylvania 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 Pennsylvania state legislature has provided both a Living Will and a Health Care Surrogate appointment document for use by the public. As this instrument was structured through specific state guidelines, it 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 statement of your values and wishes. Or you may complete only **Section II**, naming only someone to speak for you. However, only partial completion may leave your family and others with insufficient evidence to support your wishes in the future, or leave them unsure who is to speak for you. Thus, omitting either section may cause your loved ones difficulty if they must ever make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

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.

To complete the document, you should **initial** in the underlined spaces beside each of 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:
LIVING WILL DECLARATION

(Pursuant to Pennsylvania Statute §5404(b))

DECLARATION

I, _____, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures used to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

Specific Treatment Concerns:

In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment (*initial all that apply*):

I do (____), or I do not (____) want cardiac resuscitation (CPR).

I do (____), or I do not (____) want mechanical respiration (a breathing machine) used.

I do (____), or I do not (____) want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water) given to me.

I do (____), or I do not (____) want blood or blood products used.

I do (____), or I do not (____) want any form of surgery or invasive diagnostic tests.

I do (____), or I do not (____) want kidney dialysis.

I do (____), or I do not (____) want antibiotics.

(I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.)

Regarding organ and tissue donation:

I do (____), or I do not (____) want to make an anatomical gift of all or part of my body, subject to the following limitations, if any (*total body donation requires advance arrangements with a research institution, medical school, or university*): _____

Other instructions: _____

I made this declaration on this, the _____ day of _____, 20_____

(Declarant's signature)

(Declarant's address)

Statement of Witnesses

The declarant (or a person on behalf of and at the direction of declarant) knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness: _____

Printed Name: _____

Address: _____

Witness: _____

Printed Name: _____

Address: _____

SECTION II:
HEALTH CARE SURROGATE
APPOINTMENT

(Pursuant to Pennsylvania Statute §5404(b))

I do recognize and acknowledge my right to appointment someone to represent me in making medical treatment decisions in my behalf, if I am unable to make them for myself. Therefore:

Intent to Appoint (*initial only one*):

I do (____), or I do not (____) want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and in a terminal condition or in a state of permanent unconsciousness.

Name of Surrogate: _____

Address: _____

Telephone: Home:(____) ____ - _____ Work:(____) ____ - _____

Cell Phone or Pager: (____) ____ - _____ E-mail: _____

Name and address of substitute surrogate (if surrogate above is unable to serve):

Alternate Surrogate: _____

Address: _____

Telephone: Home:(____) ____ - _____ Work:(____) ____ - _____

Cell Phone or Pager: (____) ____ - _____ E-mail: _____

I made this appointment on this _____ day of _____, 20_____

(Declarant's signature)

(Declarant's address)

Statement of Witnesses

The declarant (or a person on behalf of and at the direction of declarant) knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness: _____

Printed Name: _____

Address: _____

Witness: _____

Printed Name: _____

Address: _____