DOWNLOAD COVERSHEET:

This is a "standard" advance directive for your territory, 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

Puerto Rico Residents

Statutory Compliant
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For

Puerto Rico Residents

Statutory Compliant
Advance Directive for
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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 Puerto Rico Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 21 or older): to document your personal wishes, and to have these wishes followed ~~*

The Puerto Rico legislature has provided statutes guiding the construction of both an Advance Statement of Will and a Designation of Health Care Executor for use by the public. Collectively, these documents are known as "advance directives." As the content of these documents was provided by your government, each is in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read each carefully to ensure that your advance directives are 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 make decisions 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 make this known 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 *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should 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, 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:

ADVANCE STATEMENT OF WILL

(Puerto Rico Living Will)

(Pursuant to CCPR Title 24, Part VII, Chapter 152 §3651 through §3663)

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1. INTRODUCTION: *Puerto Rico statutes provide for an adult, having capacity, to leave personal health care instructions in an "Advance Statement of Will." The following pages constitute such instructions. You should complete this section with directions that are as clear as possible, to better guide others in the event you are unable to make or communicate your own health care wishes at any time in the future.*

   *The Puerto Rico Advance Statement of Will is specifically designed to assist persons wishing to control their medical treatment when in either a terminal condition, or a persistent vegetative state. The statutes define a "**terminal condition**" as "an incurable, medically diagnosed...illness or health condition, which according to the best judgment of the physician shall cause the death of the patient within a term of not more than six (6) months" (§3651(c)). A "**Persistent Vegetative State**" is defined as, "a state of unconsciousness in which there is no cortical or cognizant brain function and for which no real possibility of recovery exists, according to established medical guidelines" (§3651(d)). Most of us think of this as a permanent and total coma.*

2. I have chosen *not* to complete an Advance Statement of Will at this time, but I *do* want to complete a Designation of Executor (*skip to page 6*):

   Signature: _____ Date: _____

   OR,

3. I, _____, being of sound mind, and acting willingly and without duress, fraud or undue influence, herein direct that the instructions provided in Section I of this document represent my Advance Statement of

Will and health care treatment wishes. It is my intent that these instructions be used to guide to any agent, mandatory, proxy, representative, surrogate, physician, judge, or court-appointed guardian or conservator, or family member, as well as any other person or entity providing or overseeing my care, or making medical decisions in my behalf. These instructions shall be binding upon all involved to the fullest extent allowed by law.

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4. ***Clarifying "Medical Treatment"***:

Puerto Rico statutes define life-sustaining "medical treatment" as "any type of medical treatment, procedure, or intervention...[used] to sustain, restore, or establish vial functions...with the sole purpose of delaying the time of death artificially, when...death is imminent regardless of whether such procedures are used. These procedures include cardiopulmonary resuscitation, diagnostic tests, dialysis, medications, respirators, surgery, and invasive diagnostic procedures, blood transfusions, and blood-derived products" *(§3651(b))*. Puerto Rico statutes also specify that "no declarant shall prohibit...available medical resources...to relieve pain or to hydrate and feed him/her, unless death is imminent and/or the body can no longer absorb the nutrients and hydration that is administered" *(§3652)*.

5. ***Statement of Wishes***: The following statements are my wishes and health care instructions in the event I am ever diagnosed with a terminal condition, or as being in a persistent vegetative state (a permanent coma).

6. *Regarding Terminal Illness*: If I am ever found to be in a terminal condition, due to disease, illness, or injury, where death is expected within a term of not more than six (6) months, then:

_____ I *do* want "life-sustaining treatment" to be used to prolong my life.
_____ I am *undecided* about the use of "life-sustaining treatment" to prolong my life, and I defer to my physician and family to decide.
_____ I do *not* want "life-sustaining treatment" used to prolong my life.

Additional Comments: _____

7. *Regarding a Persistent Vegetative State*: If I ever diagnosed as being in a persistent vegetative state, as a condition of unconsciousness in which there is no cortical or cognizant brain function, and from which no real possibility of recovery exists, then:

_____ I *do* want "life-sustaining treatment" to be used to prolong my life.
_____ I am *undecided* about the use of "life-sustaining treatment" to prolong my life, and I defer to my physician and family to decide.
_____ I do *not* want "life-sustaining treatment" used to prolong my life.

Additional Comments: _____

8. *Other Wishes and Instructions*: Puerto Rico statutes specify that an Advance Statement of Wishes may include "any other order pertaining to his/her medical care, whose viability shall be professionally evaluated by the physicians in charge

of his or her treatment" *(§3653)*. Any additional instructions I may have include:

_____
_____
_____
_____
_____
_____

9. ***Limitations and Restrictions***: Any further statutory limitations or restrictions imposed are included here. You may also add any further limits or restrictions you desire, as well.

10. *Pregnancy*. Puerto Rico statutes specify that if you are discovered to be pregnant at the time you are diagnosed with a qualifying condition, any refusal of life sustaining medical treatment must be postponed until the pregnancy has ended.

11. *Other Restrictions or Limitations*. _____
_____
_____
_____
_____

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12. ***Statement and Signature of Principal and Witnesses***:

These directions express my legal right to accept or refuse treatment under the laws of the Commonwealth of Puerto Rico. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

Severability: If any word, part, or provision of this Statement or its application to any person or circumstance is found to be invalid for any reason, that provision shall be severed without affecting any other power, authority, or application of this document which can be given effect without the invalid part, whether its directives are exercised by case law, common law, federal law, or statutory law.

By signing below, I indicate that I am fully aware of the contents of this document, and understand its full purpose, effect, and import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document. I am acting voluntarily and without fraud, duress or undue influence.

(*Sign before a notary public or a person authorized to authenticate signatures*)

13. Signed: _____

Date: _____

Address: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC:

14. Commonwealth of Puerto Rico,

County/Municipality: _____ }

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence (describe:_____)) to be the person(s) whose name(s) is/are subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed. I am not the agent, executor, proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

Notary Seal:

_____
Signature of Notary Public/Authenticator

_____
Date Commission Expires

SECTION II:

DESIGNATION OF HEALTH CARE EXECUTOR

(*Pursuant to the Civil Code of Puerto Rico, Title 24, Part VII, Chapter 152, §3652*)

15. INTRODUCTION: *Puerto Rico statutes governing the Advance Statement of Will provide for the appointment of an "executor" to make health care decisions "regarding the acceptance or rejection of treatment in the event that the declarant is unable to communicate" (§3652). The individual so named must be at least 21 years of age. If you do not name an executor, the statutes provide for "the closest, eldest relative of legal age" to be named to act as your executor in the event further decisions are needed (§3652).*

16. ***Be it known that I***:

Full Legal Name: _____

Date of Birth: _____

Street Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

~~ Intend by this document to appoint an Executor for Health Care. This Designation shall not be affected by my later disability, incompetency, or incapacity (as the "principal" herein). I am of sound mind, and state that I am completing this document voluntarily and without duress. This Designation is for the purpose of appointing someone to act in my place to make medical decisions for me if I become unable to make or communicate them for myself, and to implement any directions found within my Advance Statement of Will . This Designation is effective when, in the opinion of at least one licensed medical doctor who has personally examined me, I am no longer able make or communicate personal medical treatment decisions for myself. By this document I also revoke any prior Designation of Health Care Executor that I may have created.

17. I understand that I am <u>not</u> required to choose an executor, but recognize that by doing so I may more fully ensure that my wishes are represented and carried out. Therefore:

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

_____ I do <u>not</u> want to choose a health care executor at this time (*or I have no one appropriate to the task*). However, I instruct that Section I of this document be recognized as a declaration of my wishes (*proceed now to sign on page 7*);

OR,

_____ I <u>do</u> wish to appoint a health care executor. I recognize that this person should <u>*not*</u> be my health care provider nor an employee of my health care provider, nor an owner, operator or employee of any facility in which I receive care – unless the individual named is also related to me by blood, marriage or adoption. The person I have chosen to act as my executor and to whom I give **full** authority to make all medical and health care decisions for me at any time during which I am unable to make them for myself, is:

18. **Name of Executor**: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

19. If for any reason I revoke the authority of my executor, or this individual is unavailable, unable, unwilling, or otherwise ineligible to make decisions for me, the following individuals (*to act alone and successively, in order of priority as listed*) are authorized to serve as alternates:

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

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

22. I direct my executor to act in his/her best understanding of what my wishes would have been. And, where not reasonably sure of what I would have wanted, to act according to his/her belief in my interests as determined from his/her knowledge of my personal and family affairs, and other goals and values in life. The authority of my executor shall not be terminated *unless* it appears that he or she is clearly and obviously not acting in accordance with my known wishes, or is overwhelmingly ignoring my best interests if my wishes are not otherwise known.

STATEMENT AND SIGNATURE OF PRINCIPAL/GRANTOR:

23. This document is governed by Puerto Rico law, although I request that it be honored in any state, territory, or country in which I may be found.

By signing below, I indicate that I am fully aware of the contents of this document, and understand its purpose, effect, consequences, and full import. Further, I am of legal age, and I am emotionally and mentally competent to complete this document.

24. Signed:_____ Date: _____

_____ _____
At: (City) (County/Municipality)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC:

25. Commonwealth of Puerto Rico,

County/Municipality: _____ }

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence (describe:_____)) to be the person(s) whose name(s) is/are subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed. I am not the agent, executor, proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

_____ **Notary Seal:**

Signature of Notary Public/Authenticator

_____

Date Commission Expires

USE OF PHOTOCOPIES AND FACSIMILES:

26. A photocopy (photostatic copy) or electronic facsimile ("fax") of this document shall be deemed as valid as the original. I understand I should keep the original copy, and give copies of the original to 1) my executor and alternates, 2) my physician(s), 3) members of my family and others who might be called in the event of a medical emergency, and 4) any hospital or other health care facility where I receive treatment. My executor(s) and my family or friends should be directed to give a copy of this directive to my health care provider(s) or physician(s) upon my admission to a medical facility.

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27. INDIVIDUALS AND INSTITUTIONS WHO HAVE BEEN GIVEN COPIES OF THIS ADVANCE DIRECTIVE

Name: ______________________________
Address ______________________________
____
Phone (_____) ______ - ______________
Fax: (_____) ______ - ______________
E-mail: ______________________________

Name: ______________________________
Address: ______________________________
____
Phone (_____) ______ - ______________
Fax: (_____) ______ - ______________
E-mail: ______________________________

Name: ______________________________
Address ______________________________
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Address: ______________________________
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Phone (_____) ______ - ______________
Fax: (_____) ______ - ______________
E-mail: ______________________________

For additional copies of this directive, or other related materials, please contact Lifecare Directives, LLC, at:

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