**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. *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

## South Carolina Residents

*Statutory Compliant Advance Directive for Health Care Choices*

~ Lifecare Directives ~

# Statutory Advance Directive

For

South Carolina Residents

Statutory Compliant
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.

# *Advance Health Care Directive For South Carolina Residents*

_____ _____

*Print Full Name* *Date of Birth*

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

The South Carolina state legislature has provided statutes containing both a living will and a Power of Attorney for Health Care for use by the public. Collectively, these documents are known as "advance directives." As the content of these documents was designed by your state 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 them carefully to ensure that your advance directives are fully and properly filled out.

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***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.

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***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.

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## Section I:
## DECLARATION OF A DESIRE FOR A NATURAL DEATH

*(SC Code of Laws, Title 44, Chapter 77, §44-77-10 through §44-77-160)*

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STATE OF SOUTH CAROLINA )
)
County of _____ )

I, _____, Declarant, being at least eighteen years of age and a resident of and domiciled in the City of _____, County of _____, State of South Carolina, make this Declaration on this _____ day of _____, 20_____.

I wilfully and voluntarily make known my desire that no life-sustaining procedures be used to prolong my dying if my condition is terminal or if I am in a state of permanent unconsciousness, and I declare:

If at any time I have a condition certified to be a terminal condition by two physicians who have personally examined me, one of whom is my attending physician, and the physicians have determined that my death could occur within a reasonably short period of time without the use of life-sustaining procedures or if the physicians certify that I am in a state of permanent unconsciousness and where the application of life-sustaining procedures would serve only to prolong the dying process, I direct that the procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure necessary to provide me with comfort care.

INSTRUCTIONS CONCERNING ARTIFICIAL NUTRITION AND HYDRATION

1. If my condition is terminal and could result in death within a reasonably short time:
(*initial <u>one</u> of the following statements*)
_____ I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.
_____ I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

2. If I am in a persistent vegetative state or other condition of permanent unconsciousness:
(*initial <u>one</u> of the following statements*)
_____ I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.
_____ I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

3. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this Declaration be honored by my family and physicians and any health facility in which I may be a patient as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from the refusal.

I am aware that this Declaration authorizes a physician to withhold or withdraw life-sustaining procedures. I am emotionally and mentally competent to make this Declaration.

**APPOINTMENT OF AN AGENT**

(*optional*)

4. You may give another person authority to revoke this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.

**Name of Revocation Agent**: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

5. You may give another person authority to enforce this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.

**Name of Enforcing Agent**: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

**REVOCATION PROCEDURES**

(*in required boldface type*)

**This declaration may be revoked by any one of the following methods. However, a revocation is not effective until it is communicated to the attending physician.**

**1) by being defaced, torn, obliterated, or otherwise destroyed, in expression of your intent to revoke, by you or by some person in your presence and by your direction. Revocation by destruction of one or more of multiple original declarations revokes all of the original declarations;**

**2) by a written revocation signed and dated by you expressing your intent to revoke;**

**3) by your oral expression of your intent to revoke the declaration. An oral revocation communicated to the attending physician by a person other than you is effective only if:**

**a) the person was present when the oral revocation was made;**

**b) the revocation was communicated to the physician within a reasonable time;**

**c) your physical or mental condition makes it impossible for the physician to confirm through subsequent conversation with you that the revocation has occurred.**

**To be effective as a revocation, the oral expression clearly must indicate your desire that the declaration not be given effect or that life-sustaining procedures be administered;**

**4) if you, in the space above, have authorized an agent to revoke the declaration, the agent may revoke orally or by a written, signed, and dated instrument. An agent may revoke only if you are incompetent to do so. An agent may revoke the declaration permanently or temporarily.**

**5) by your executing another declaration at a later time**.

SIGNATURE OF DECLARANT

_____

Signature of Declarant

**WITNESSES AFFIDAVIT**

STATE OF SOUTH CAROLINA )
)
COUNTY OF _____ )

We, _____ and _____, as the undersigned witnesses to the foregoing Declaration, which is dated on the _____ day of the month of _____, in the year 20_____, with at least one of us being first duly sworn, do declare to the undersigned authority, on the basis of our best information and belief, that this Declaration was on the above date signed by the declarant as and

for his DECLARATION OF A DESIRE FOR A NATURAL DEATH in our presence and we, at his request and in his presence, and in the presence of each other, subscribe our names as witnesses on that date. The declarant is personally known to us, and we believe him to be of sound mind. Each of us affirms that he is qualified as a witness to this Declaration under the provisions of the South Carolina Death With Dignity Act in that he is not related to the declarant by blood, marriage, or adoption, either as a spouse, lineal ancestor, descendant of the parents of the declarant, or spouse of any of them; nor directly financially responsible for the declarant's medical care; nor entitled to any portion of the declarant's estate upon his decease, whether under any will or as an heir by intestate succession; nor the beneficiary of a life insurance policy of the declarant; nor the declarant's attending physician; nor an employee of the attending physician; nor a person who has a claim against the declarant's decedent's estate as of this time. No more than one of us is an employee of a health facility in which the declarant is a patient. If the declarant is a resident in a hospital or nursing care facility at the date of execution of this Declaration, at least one of us is an ombudsman designated by the State Ombudsman, Office of the Governor.

Witness Signature _____

Witness Signature _____

**CERTIFICATE OF NOTARY PUBLIC**

Subscribed before me by _____, the declarant, and

subscribed and sworn to before me by _____, the witnesses,

this _____ day of _____, 20_____.

Notary Signature _____

Notary Public for _____

Date commission expires: _____

NOTARY SEAL:

## Section II:
## HEALTH CARE POWER OF ATTORNEY

*(SC Code of Laws, Title 62, Article 5, Part 5, §62-5-501 through §62-5-505)*

**INFORMATION ABOUT THIS DOCUMENT**

(*in required capitalization*)

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU NAME AS YOUR AGENT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU CANNOT MAKE THE DECISION FOR YOURSELF. THIS POWER INCLUDES THE POWER TO MAKE DECISIONS ABOUT LIFE-SUSTAINING TREATMENT. UNLESS YOU STATE OTHERWISE, YOUR AGENT WILL HAVE THE SAME AUTHORITY TO MAKE DECISIONS ABOUT YOUR HEALTH CARE AS YOU WOULD HAVE.

2. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENTS OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TREATMENT YOU DO NOT DESIRE OR TREATMENT YOU WANT TO BE SURE YOU RECEIVE. YOUR AGENT WILL BE OBLIGATED TO FOLLOW YOUR INSTRUCTIONS WHEN MAKING DECISIONS ON YOUR BEHALF. YOU MAY ATTACH ADDITIONAL PAGES IF YOU NEED MORE SPACE TO COMPLETE THE STATEMENT.

3. AFTER YOU HAVE SIGNED THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF IF YOU ARE MENTALLY COMPETENT TO DO SO. AFTER YOU HAVE SIGNED THIS DOCUMENT, NO TREATMENT MAY BE GIVEN TO YOU OR STOPPED OVER YOUR OBJECTION IF YOU ARE MENTALLY COMPETENT TO MAKE THAT DECISION.

4. YOU HAVE THE RIGHT TO REVOKE THIS DOCUMENT, AND TERMINATE YOUR AGENT'S AUTHORITY, BY INFORMING EITHER YOUR AGENT OR YOUR HEALTH CARE PROVIDER ORALLY OR IN WRITING.

5. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A SOCIAL WORKER, LAWYER, OR OTHER PERSON TO EXPLAIN IT TO YOU.

6. THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS TWO PERSONS SIGN AS WITNESSES. EACH OF THESE PERSONS MUST EITHER WITNESS YOUR SIGNING OF THE POWER OF ATTORNEY OR WITNESS YOUR ACKNOWLEDGMENT THAT THE SIGNATURE ON THE POWER OF ATTORNEY IS YOURS.

THE FOLLOWING PERSONS MAY **NOT** ACT AS WITNESSES:

A. YOUR SPOUSE; YOUR CHILDREN, GRANDCHILDREN, AND OTHER LINEAL DESCENDANTS; YOUR PARENTS, GRANDPARENTS, AND OTHER LINEAL ANCESTORS; YOUR SIBLINGS AND THEIR LINEAL DESCENDANTS; OR A SPOUSE OF ANY OF THESE PERSONS.

B. A PERSON WHO IS DIRECTLY FINANCIALLY RESPONSIBLE FOR YOUR MEDICAL CARE.

C. A PERSON WHO IS NAMED IN YOUR WILL, OR, IF YOU HAVE NO WILL, WHO WOULD INHERIT YOUR PROPERTY BY INTESTATE SUCCESSION.

D. A BENEFICIARY OF A LIFE INSURANCE POLICY ON YOUR LIFE.

E. THE PERSONS NAMED IN THE HEALTH CARE POWER OF ATTORNEY AS YOUR AGENT OR SUCCESSOR AGENT.

F. YOUR PHYSICIAN OR AN EMPLOYEE OF YOUR PHYSICIAN.

G. ANY PERSON WHO WOULD HAVE A CLAIM AGAINST ANY PORTION OF YOUR ESTATE (PERSONS TO WHOM YOU OWE MONEY).

IF YOU ARE A PATIENT IN A HEALTH FACILITY, NO MORE THAN ONE WITNESS MAY BE AN EMPLOYEE OF THAT FACILITY.

7. YOUR AGENT MUST BE A PERSON WHO IS 18 YEARS OLD OR OLDER AND OF SOUND MIND. IT MAY NOT BE YOUR DOCTOR OR ANY OTHER HEALTH CARE PROVIDER THAT IS NOW PROVIDING YOU WITH TREATMENT; OR AN EMPLOYEE OF YOUR DOCTOR OR PROVIDER; OR A SPOUSE OF THE DOCTOR, PROVIDER, OR EMPLOYEE; UNLESS THE PERSON IS A RELATIVE OF YOURS.

8. YOU SHOULD INFORM THE PERSON THAT YOU WANT HIM OR HER TO BE YOUR HEALTH CARE AGENT. YOU SHOULD DISCUSS THIS DOCUMENT WITH YOUR AGENT AND YOUR PHYSICIAN AND GIVE EACH A SIGNED COPY. IF YOU ARE IN A HEALTH CARE FACILITY OR A NURSING CARE FACILITY, A COPY OF THIS DOCUMENT SHOULD BE INCLUDED IN YOUR MEDICAL RECORD.

HEALTH CARE POWER OF ATTORNEY

1. DESIGNATION OF HEALTH CARE AGENT

I, _____, hereby appoint:

(*The same as your "enforcing agent," if appointed, in your living will*)

**Name of Agent**: _____

Address: _____

Telephone: Home: _____ Work: _____

Cell Phone or Pager: _____ E-mail: _____

~~ as my agent to make health care decisions for me as authorized in this document.

2. EFFECTIVE DATE AND DURABILITY

By this document I intend to create a durable power of attorney effective upon, and only during, any period of mental incompetence.

3. AGENT'S POWERS

I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in this document or otherwise expressed by me or known to my agent. In making any decision, my agent shall

attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my agent cannot determine the choice I would want made, then my agent shall make a choice for me based upon what my agent believes to be in my best interests. My agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below. Accordingly, unless specifically limited by Section E, below, my agent is authorized as follows:

A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;

B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death;

C. To authorize my admission to or discharge, even against medical advice, from any hospital, nursing care facility, or similar facility or service;

D. To take any other action necessary to making, documenting, and assuring implementation of decisions concerning my health care, including, but not limited to, granting any waiver or release from liability required by any hospital, physician, nursing care provider, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply.

E. The powers granted above do not include the following powers or are subject to the following rules or limitations:

4. ORGAN DONATION (*initial only <u>one</u> space, below*):

My agent <u>may</u> _____; or, may <u>not</u> _____ consent to the donation of all or any of my tissue or organs for purposes of transplantation.

5. EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH (LIVING WILL)

I understand that if I have a valid Declaration of a Desire for a Natural Death, the instructions contained in the Declaration will be given effect in any situation to which they are applicable. My agent will have authority to make decisions concerning my health care only in situations to which the Declaration does not apply.

6. STATEMENT OF DESIRES AND SPECIAL PROVISIONS

With respect to any Life-Sustaining Treatment, I direct the following:

(*initial only <u>one</u> of the following 4 paragraphs*)

(1) _____ GRANT OF DISCRETION TO AGENT. 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, my personal beliefs, the expense involved and the quality as well as the possible extension of my life in making decisions

concerning life-sustaining treatment.

***OR***,

(2) _____ DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment:

a. if I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time; or

b. if I am in a state of permanent unconsciousness.

***OR***,

(3) ___ DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

***OR***,

(4) ___ DIRECTIVE IN MY OWN WORDS: _____

_____

_____

_____

_____

7. STATEMENT OF DESIRES REGARDING TUBE FEEDING

With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that

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

_____ I do not want to receive these forms of artificial nutrition and hydration, and they may be withheld or withdrawn under the conditions given above.

***OR***,

_____ I do want to receive these forms of artificial nutrition and hydration.

(***If You Do Not Initial Either of the above Statements, Your Agent Will <u>Not</u> Have Authority to Direct That Nutrition and Hydration Necessary for Comfort Care or Alleviation of Pain Be Withdrawn***.)

8. SUCCESSORS

If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following as successors to my agent, each to act alone and successively, in the order named.

A. *Alternate Agent #1*:_____

Address: _____

Telephone: Home: _____ Work: _____

Cell Phone or Pager: _____ E-mail: _____

B. *Alternate Agent #2*: _____
Address: _____
Telephone: Home: _____ Work: _____
Cell Phone or Pager: _____ E-mail: _____

9. ADMINISTRATIVE PROVISIONS

A. I revoke any prior Health Care Power of Attorney and any provisions relating to health care of any other prior power of attorney.

B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

10. UNAVAILABILITY OF AGENT

If at any relevant time the Agent or Successor Agents named herein are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Health Care Power of Attorney on this, the _____ day of _____, 20 _____.

My current home address is: _____
_____

Signature: _____

Printed Name: _____

WITNESS STATEMENT

I declare, on the basis of information and belief, that the person who signed or acknowledged this document (the principal) is personally known to me, that he/she signed or acknowledged this Health Care Power of Attorney in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not related to the principal by blood, marriage, or adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them. I am not directly financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of an insurance policy on the principal's life, nor do I have a claim against the principal's estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health facility in which the principal is a patient. I am not appointed as Health Care Agent or Successor Health Care Agent by this document.

**Witness #1:**

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

Residence Address: _____

_____

**Witness #2:**

Signature: _____ Date: _____

Print Name: _____ Telephone: _____

Residence Address: _____

_____

**CERTIFICATE OF NOTARY PUBLIC**

*(witnesses, above, are required; notarization, below, is optional)*

Subscribed before me by _____, the declarant, and subscribed and sworn to before me by _____, the witnesses, this _____ day of _____, 20_____.

Notary Signature _____

Notary Public for _____

Date commission expires: _____

NOTARY SEAL: