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 ~

Advance Health Care Plan

For

Tennessee 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.

~ Lifecare Directives ~

Advance Health Care Plan

For

Tennessee Residents

Statutory Compliant
Advance Directive for
Health Care Choices

Advance Health Care Plan
For Tennessee 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 Tennessee state legislature has provided statutes governing the content of advance directives (i.e., the living will and the power of attorney for health care). The Tennessee Department of Health, Board for Licensing Health Care facilities, at the direction of the legislature, then utilized these statutes to design an Advance Care Plan (the new name for the Tennessee living will) and an Appointment of Health Care Agent (as the Tennessee power of attorney for health care is now known). As these documents were designed by your state government, they should be in full compliance with all applicable statutes and laws.

There is a brief introduction which summarizes the scope and purpose of these documents, as well as providing directions for their completion. Read this carefully to ensure that your Advance Directive is fully and properly filled out.

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

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. You may choose to complete only ***Section I***, providing only a living will statement of your values and wishes. Or you may complete only ***Section II***, just appointing someone to make treatment decisions in your behalf. Omitting Section I may leave your family and others without evidence to support your wishes in the future, and omitting Section II may leave your family unsure who is to speak for you and make decisions in your behalf. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. Therefore, you are strongly urged to complete both portions of this Advance Health Care Plan.

To complete either or both documents, 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 CARE PLAN

(Agent Appointment, Living Will and Health Care Instructions)

(Pursuant to the TN Health Care Decisions Act: Title 68:Ch.11:§1701 to §1715)

---

1. INTRODUCTION: *Competent adults and emancipated minors may provide advance health care instructions using this form, or any other form of their choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.*

2. ***Be it known that I***,

Full Legal Name: _____

Date of Birth: _____

Street Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

~~ hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

3. **Agent**: I want the following person to make health care decisions for me:

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

5. Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

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

Quality of Life:

7. I want my doctors to help me maintain an acceptable quality of life, including adequate pain management. A quality of life that is unacceptable to me, means when I have any of the following conditions (*you can initial as many of these items as you wish*):

_____ Permanent Unconscious Condition: In this situation I have become totally unaware of people or surroundings, with little chance of ever waking up from the coma.

_____ Permanent Confusion: In this situation I have become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

_____ Dependent in all Activities of Daily Living: In this situation I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.

_____ End-Stage Illness: In this situation, I have an illness that has reached its final stages in spite of full medical treatment. *Examples include*: widespread cancer that does not respond anymore to treatment; or, chronic and/or damaged heart and lungs, where medically provided oxygen is needed most of the time and my activities are greatly limited due to regular feelings of suffocation.

Medical Treatments of Special Concern:

8. If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I then direct that medically appropriate treatment be provided as follows. (*Initialing "yes" means that I WANT the treatment; initialing "no" means that I do NOT want the treatment*):

- CPR (*Cardiopulmonary Resuscitation*): An effort to try make the heart beat again and to try and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
  _____ Yes; _____ No.

- Life Support / Other Artificial Medical Support: The continuous use of a breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other vital organs to continue to work.
  _____ Yes; _____ No.

- Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition, but will not help the main illness.
  _____ Yes; _____ No.

- Tube Feeding / IV Fluids: Use of tubes to deliver food and water to a patient's stomach, and/or the use of IV fluids into a vein which would include artificially delivered nutrition and hydration.
  _____ Yes; _____ No.

Other Instructions:

9. Here you may write out any other instructions you wish, such as the desire for hospice care, specific burial arrangements, etc: _____
_____
_____
_____
_____
(*Attach additional pages, if necessary*)

Organ Donation (*optional*):

10. Upon my death, I wish to make the following anatomical gift(s):
(*initial only one*)
_____ Any needed organs or tissues.
_____ My entire body (*requires advance arrangements with a hospital, medical school, or special research program*)
_____ Only the following organs or tissues: _____
_____
_____

Your Signature:

11. Your signature should either be witnessed by two competent adults, or else notarized. If witnessed, neither witness should be the person you appointed as your agent, at least one of the witnesses should be someone who is not related to your nor entitled to any part of your estate.

12. Signed: _____

Date: _____

Address: _____

(*To be legally valid, either Option 1 or Option 2 must be completed*)

Option 1: Statement of Witnesses

13. *First Witness*: I am a competent adult who has not been named as a "health care agent" or other surrogate for the individual establishing this document:

Witness: _____
Printed Name:_____
Address: _____

14. *Second Witness*: I am a competent adult who has not been named as a "health care agent" or other surrogate for the individual establishing this document. Further, I am not related to the individual by blood, marriage or adoption, nor am I entitled to any portion of his or her estate upon death by a will or any codicil thereto, nor do I have a claim against or other entitlement to any of his or her estate by any other operation of law.

Witness: _____
Printed Name:_____
Address: _____

Option 2: Notarization

State of Tennessee
County of _____

15. I am a Notary Public for the State and County named above. The person who signed this instrument is personally known to me (or was proved, on the basis of satisfactory evidence) to be the person who signed as Principal, above. The individual personally appeared before me and signed, or acknowledged the signature as his or her own. I declare under penalty of perjury that the individual appears to be of sound mind and under no duress, fraud, or undue influence.

_____ _____
Signature Notary Public / Date Date Commission Expires

SECTION II:
APPOINTMENT OF HEALTH CARE AGENT

(TN Health Care Decisions Act: Title 68:Ch.11:§1701 to §1715)

16. INTRODUCTION: *This section lets you name a person to make health care decisions for you if you cannot make them for yourself. The person must be at least 18 years of age. Unless you indicate otherwise, the powers which you grant through this document will include the authority to make health care decisions, including life-sustaining treatment decisions. If you have questions, you should seek further counsel and advice.*

17. I, _____, being of sound mind, and acting willingly and without duress, fraud or undue influence, do hereby name the person identified below as my health care agent. I grant to this person **full** authority to consent, refuse consent, renew or withdraw consent to any treatment, tests, medications, care, services, surgery or therapies used to diagnose or treat any physical or mental condition. This authorization includes the authority to consent to the provision, withholding or withdrawal of any life-sustaining treatment or procedure *even* if the consent or refusal of such will result in my death; **and** to legally act in *every* other matter related to my health and personal care with that same authority I would have, without incurring any personal, legal or financial liability for such.

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

19. If for any reason I revoke the authority of my agent, or this individual is unavailable, unable, unwilling, or otherwise ineligible to make decisions for me, the following individual is authorized to serve as an alternate agent:

20. **Name of Alternate:**_____
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 agent (and successors) 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.

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.

23. Signed: _____

Date: _____

Address: _____

(*To be legally valid, either Option 1 or 2 must be completed. Lifecare staff recommend both*)

Option 1: Statement of Witnesses

24. *First Witness*: I am a competent adult who has not been named as a "health care agent" or other surrogate for the individual establishing this document:

Witness: _____
Printed Name:_____
Address: _____

25. *Second Witness*: I am a competent adult who has not been named as a "health care agent" or other surrogate for the individual establishing this document. Further, I am not related to the individual by blood, marriage or adoption, nor am I entitled to any portion of his or her estate upon death by a will or any codicil thereto, nor do I have a claim against or other entitlement to any of his or her estate by any other operation of law.

Witness: _____
Printed Name:_____
Address: _____

Option 2: Notarization

State of Tennessee
County of _____

26. I am a Notary Public for the State and County named above. The person who signed this instrument is personally known to me (or was proved, on the basis of satisfactory evidence) to be the person who signed as Principal, above. The individual personally appeared before me and signed, or acknowledged the signature as his or her own. I declare under penalty of perjury that the individual appears to be of sound mind and under no duress, fraud, or undue influence.

_____ _____
Signature Notary Public / Date Date Commission Expires

What to do With this Advance Directive:

27. After completing your advance directive (Section I or Section II), you should then:
    - Provide a copy to your physician(s)
    - Keep a copy in your personal files, where it is accessible to others.
    - Tell your closest relatives and friends what is in the document.
    - provide a copy to the person(s) you named as you health care agent.

USE OF PHOTOCOPIES AND FACSIMILES:

28. A photocopy (photostatic copy) or electronic facsimile ("fax") of this document shall be deemed as valid as the original. My agent(s) and/or my family or friends should give a copy of this directive to my health care provider(s) or physician(s) upon any request.

29. INDIVIDUALS AND/OR INSTITUTIONS WHO HAVE BEEN GIVEN COPIES OF THIS ADVANCE DIRECTIVE

Name: _____
Address _____
_____
Phone (_____) _____ - _____
Fax: (_____) _____ - _____
E-mail: _____

Name: _____
Address: _____
_____
Phone (_____) _____ - _____
Fax: (_____) _____ - _____
E-mail: _____

Name: _____
Address _____
_____
Phone (_____) _____ - _____
Fax: (_____) _____ - _____
E-mail: _____

Name: _____
Address: _____
_____
Phone (_____) _____ - _____
Fax: (_____) _____ - _____
E-mail: _____

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

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