Last Name Middle Initial First Name DOB

ADVANCE DIRECTIVE

Indiana Health Care Representative

My Health Care Representative can make decisions for me if I cannot make and share my own health care decisions. These decisions include:

- Agreeing to medical treatment
- Refusing medical treatment
- Stopping medical treatment
- Arranging comfort care

My Health Care Representative must follow my wishes and values. My values include my ideas about dignity and quality of life. If my Health Care Representative does not know my wishes, my Health Care Representative must act in good faith and in my best interests.

I keep the right to make my own health care decisions if I am able.

I name ________________________________ as my primary Health Care Representative. Their phone number is _______________________.

If my primary Health Care Representative named above is not able or available to act for me, I name _________________________ as my backup Health Care Representative.
Their phone number is ___________________________.

Date signed:____________________

____
My signature (Declarant)

____
Printed name of adult (if any) who signs for Declarant if physically unable to sign

____
My printed name (Declarant)

____
Initial

By initialing this document, I verify that I have signed this Advance Directive remotely, via telephonic interaction throughout the signing process, in the presence of two (2) witnesses

Last Name Middle Initial First Name DOB

Complete this Form by using either the left or right block below.

Signatures of 2 Adult Witnesses

Each of the undersigned Witnesses confirms that he or she has received satisfactory proof of the identity of the Declarant and is satisfied that the Declarant is of sound mind and has the capacity to sign the above Advance Directive. **At least one of the undersigned Witnesses is not a spouse or other relative of the Declarant.**

____
Signature of Adult Witness 1

____
Printed Name of Adult Witness 1

____
Signature of Adult Witness 2

____
Printed Name of Adult Witness 2

Both declarant and witnesses declare that we have signed the Advance Directive in compliance with Indiana law.

Notarization

STATE OF INDIANA)

) SS:

COUNTY OF ________)

Before me, a Notary Public, personally appeared ____________________ ______ (*name of signing Declarant),* who acknowledged the execution of the foregoing Advance Directive as his or her voluntary act, and who, having been duly sworn, stated that any representations therein are true.

Witness my hand and Notarial Seal on this ______ day of ______, 20 ______.

____
Signature of Notary Public

____
Notary's Printed Name (*If not on seal)*

____
Commission Number *(If not on seal)*

____
Commission Expires (*If not on seal)*

____
Notary's County of Residence