INDIANA HEALTH CARE REPRESENTATIVE:
A Health Care Representative is a person you elect to make healthcare decisions, including end-of-life decisions, when it is determined by a physician that you are unable to make them on your own. You should talk with this person about your preferences regarding healthcare decisions ahead of time.

My Name

_____ _____
Full Legal Name (Also Known as "Declarant") Date of Birth (MM/DD/YYYY)

Being at least eighteen (18) years old and of sound mind, my below stated Health Care Representative is authorized to make healthcare decisions for me if I cannot make them on my own. My Health Care Representative must try to discuss decisions with me. However, if I am not able to communicate, they may make such decisions for me, after consulting with my physicians and providers, including other relevant family members. My Health Care Representative must try to follow my wishes about end of life and my 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 make decisions in my best interests. These decisions include but are not limited to:

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

I want the following person to be my Health Care Representative (HCR):

_____ _____
Name of HCR Appointed Telephone Number of HCR

If my primary healthcare representative is not able or available to act on my behalf, I would like the following person, to then, be my Health Care Representative:

_____ _____
Name of Alternate HCR Appointed Telephone Number of Alternate HCR

OPTIONAL STATEMENT OF PREFERENCES:
I would like to provide some additional guidance for my Health Care Representative on my end-of-life preferences. (Please select only one option below).

☐ The ***quality of my life*** is more important than the length of my life. If I am unable to make my own decisions and my attending physician believes that I will not recover, I do not want treatments to prolong my life or delay my death. Instead, I would want treatment or care to make me comfortable and to relieve me of pain.

☐ ***Staying alive*** is more important to me, no matter how sick I am or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible, in accordance with reasonable medical standards.

☐ I choose to NOT complete this section at this time.

REQUIRED SIGNATURES:
By signing this document, I cancel and revoke any previous health care power of attorney I may have signed in the past.

_____ _____
Signature (Declarant) Date

_____
Printed Name (Declarant)

This form must be either signed by 2 adult witnesses (below left) or notarized (below right) to be legally valid.

SIGNATURE 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

_____
Date

_____
Signature of Adult Witness 2

_____
Printed Name of Adult Witness 2

_____
Date

_____ Initial here if the Witnesses participated by phone.

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