ADVANCE MEDICAL DIRECTIVE WORKSHEET

FOR OFFICE USE ONLY	
Date:	Attorney:
Date Needed:	Reviewing Attorney:

THIS FORM MUST BE COMPLETED IN ORDER FOR THE LEGAL ASSISTANCE OFFICE TO PREPARE AN ADVANCE MEDICAL DIRECTIVE

An ADVANCE MEDICAL DIRECTIVE is exempt from any requirement of form, substance, formality or recording that is provided for advance medical directives under the laws of a State; and shall be given the same legal effect as an advance medical directive prepared and executed in accordance with the laws of the State concerned. You should, however, have this document prepared for the State where you believe it is most likely that these decisions will be made.

LIVING WILLS	**HEALTH CARE POWERS OF ATTORNEY**
An Advance Medical Directive is a written declaration (LIVING WILL) that informs a doctor of your 'quality of life' decision for a natural death and allows the doctor to act on this decision. In the "Living Will" you direct the doctor on the provision, withdrawal, or the withholding of life-prolonging procedures, including hydration and sustenance, if you are determined to be in a terminal physical condition or are in a persistent vegetative state. Alternatively, an Advance Medical Directive is a written declaration (HEALTH CARE POWER OF ATTORNEY) that authorizes another person to make health care decisions for you, under circumstances specified in the declaration, whenever you are incapable of making informed health care decisions.	A "Health Care Power of Attorney" allows you to appoint an agent who is authorized to make all health care decisions for you when you are incapacitated. This document usually includes giving your agent the power to express and execute your intentions for a natural death. Your agent will not be allowed to make medical decisions for you until a doctor certifies that you are unable to make these decision yourself (i.e. that you are incapacitated). The Health Care Power of Attorney is a much broader document than a Living Will. If you desire to execute a Health Care Power of Attorney allowing natural death decisions to be made by your agent, you should also execute a Living Will to ensure that the doctor is certain of your decision and will carry out your agent's decision on this matter.

Please prepare the requested legal document(s) using the information provided below.

____
Client's signature
Date: __________________________

PLEASE CHECK **YOUR** STATUS: ACTIVE DUTY DEPENDENT RETIREE
PLEASE CHECK SERVICE BRANCH:

NAVY	USNR	USMC	USMCR
USCG	USCGR	ARMY	USAR
USAF	USAFR		

SPONSOR'S UNIT: ______________________________

SPONSOR'S RANK/RATE: ________________________

YOUR PHONE NUMBER: _________________________

On this worksheet, you will be providing information necessary for the Legal Assistance Office to draft two documents that express your intent regarding health care decisions and/or your desire to die a natural death in the event you are unable to communicate these decisions.

CLIENT INFORMATION

1. Full Name: ____
   First / Middle / Last

2. Residence: ____
   Street Apt. / Floor

   ____
   City / State / Zip Code

   Telephone: ____
   Home Cell Work

3. Legal Domicile: ____
   City / State

Your Legal Residence (DOMICILE) is a place where you have been and which you consider your PERMANENT home. If you are on active duty or are the family member of an active duty service member, your Domicile is the place you intend to return to when you leave the service.

4. State(s) where natural death decisions will most likely be made: _______________________

5. I do do not want the Living Will to state that I prefer to die at home rather than a hospital.

6. I do do not want the Living Will to state that I authorize organ donation for transplant purposes only.

   I authorize broader organ donation to include the purposes of other medical, educational, or scientific purposes. _________ (initial if you consent)

AGENT DESIGNATION

7. I desire that the following person be my agent in the Health Care Power of Attorney (I understand that he or she will make all health care decisions for me in the event of my incapacitation):

   Full Name: ____
   First / Middle / Last

   Relationship: ____________________ (i.e. spouse, sister, brother, parent)

   Residence: ____
   Street Apt. / Floor

   ____
   City / State / Zip Code

   Telephone: ______________
   Home

8. In the event that the first person I named cannot or will not act as my agent, then I desire the following person to so act:

   Full Name: ____
   First / Middle / Last

   Relationship: ____________________ (i.e. spouse, sister, brother, parent)

   Residence: ____
   Street Apt. / Floor

   ____
   City / State / Zip Code

   Telephone: ______________
   Home

9. I specifically desire that the two people I have named above act together in making health care decisions for me.

   Yes No

GUARDIAN DESIGNATION

> Note: The guardian may, and often is, the same person designated as the first agent. A guardian of your person may be appointed for you if a court decides that one should be appointed. The guardian of your person is responsible for your physical care, which under some circumstances includes making health care decisions.

10. I specifically desire that the following person act as my guardian:

Full Name: ____
First / Middle / Last

Relationship: ____________________________ (i.e. spouse, sister, brother, parent)

Residence: ____
Street Apt. / Floor

____
City / State / Zip Code

Telephone: __________________
Home

PHYSICIAN AUTHORIZED TO DETERMINE INCOMPETENCY OR INCAPACITATION

> Note: It is not required that you specifically name a doctor. Instead, you may authorize "the attending physician" responsible for your care to make the decision

11. I desire that the following doctor make the decision regarding my incompetency or incapacity:

    The attending doctor

    My doctor: ____ (name and work number)

    Other doctor: ______________________________________ (name and work number)

    Authority:

    Jointly

    Co-equally

    Primary and alternate

DISPOSITION OF YOUR REMAINS

> Note: This provision allows your agent to donate your body parts for transplant or therapeutic, educational, or scientific purpose.

12. I specifically authorize my agent to donate my body or body parts: Yes No

DURATION OF DOCUMENTS

Note: Fill in an expiration date ONLY IF you desire the authority of your agent to end on a specific date.

14. Expiration Date: ____ (DD / MONTH / YYYY)

THE DOCUMENTS THIS OFFICE WILL PREPARE AUTHORIZE YOUR AGENT BROAD DISCRETION REGARDING YOUR MEDICAL TREATMENT AND/OR END OF LIFE CARE. YOU SHOULD TALK WITH AN ATTORNEY IF YOU WISH TO LIMIT THIS AUTHORIZATION.