

# GEORGIA

## Advance Directive

### Planning for Important Health Care Decisions

*CaringInfo*  
1731 King St., Suite 100, Alexandria, VA 22314  
[www.caringinfo.org](http://www.caringinfo.org)  
800/658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

#### **It's About How You LIVE**

*It's About How You LIVE* is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and health care providers
- E**ngage in personal or community efforts to improve end-of-life care

**Note:** The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. **If you have other questions regarding these documents, we recommend contacting your state attorney general's office.**

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## Using these Materials

### BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you could receive health care.
2. These materials include:
  - Instructions for preparing your advance directive, please read all the instructions.
  - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

### ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.
5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

## INTRODUCTION TO YOUR GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

This packet contains the **Georgia Advance Directive for Health Care**, which protects your right to refuse medical treatment that you do not want or to request treatment you do want, in the event you lose the ability to make decisions yourself. The form contains three parts, any number of which may be filled out, and a fourth signature page that must be filled out for any of the three other parts to be effective.

**Part One: Health Care Agent.** This allows you to choose someone to make health care decisions for you if you cannot (or do not want to) make health care decisions for yourself. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body.

Your health care agent's power becomes effective when your doctor determines that you are no longer able to make or communicate your health care decisions or when you decide to have your health care agent make decisions for you.

**Part Two: Treatment Preferences.** This part allows you to state your treatment preferences if you are (1) unable to communicate your treatment preferences, and (2) your physician and one other physician determine that you either have a terminal condition or are in a state of permanent unconsciousness. If you also have a health care agent, then your agent is authorized to make all decisions discussed in Part Two, but will be guided by your written Treatment Preferences as well as any other factors you may have listed in section 4 of Part One.

**Part Three: Guardianship.** This part allows you to nominate a person to be your guardian should one ever be needed.

**Part Four: Signatures.** This part needs to be filled out in order to make any of the three other parts effective. All three preceding parts are optional. You are free to fill out any or all of them.

These forms do not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney for mental health care.

*Note: These documents will be legally binding only if the person completing them is a competent adult, at least 18 years old, or an emancipated youth.*

## COMPLETING YOUR GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

### **How do I make my Advance Directive for Health Care legal?**

The law requires that you sign your document, or another person signs it in your presence and at your express direction, in the presence of two witnesses who must be at least 18 years of age and of sound mind.

Your witnesses cannot be your health care agent, someone who will knowingly inherit anything from you or otherwise gain a financial benefit from your death, or someone who is directly involved in your health care.

Only one witness can be an employee, agent, or medical staff member of the facility in which you are receiving health care.

*Note: You do not need to notarize your Georgia Advance Directive for Health Care.*

### **Whom should I appoint as my agent?**

Your health care agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your health care agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your health care agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

No physician or health care provider may act as your health care agent if he or she is directly involved in your health care.

You can appoint a second and third person as your alternate health care agent(s). The alternate(s) will step in if the first person you name as agent is unable, unwilling, or unavailable to act for you.

### **Should I add personal instructions to my Advance Directive for Health Care?**

One of the strongest reasons for naming a health care agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your health care agent carry out your wishes, but be careful that you do not unintentionally restrict your health care agent's power to act in your best interest. In any event, be sure to talk with your health care agent about your future medical care and describe what you consider to be an acceptable "quality of life."

## COMPLETING YOUR GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE (CONTINUED)

### **What if I change my mind?**

#### Revocation

You may revoke your Georgia advance directive for health care at any time, regardless of your mental or physical condition, by:

- obliterating, burning, tearing, or otherwise destroying your document,
- signing and dating a written revocation or directing another person to do so (if you are receiving health care in a health care facility, the revocation must be communicated to your attending physician) , or
- orally revoking your document in the presence of a witness, at least 18 years of age, who must sign and date a written confirmation of your revocation within 30 days (if you are receiving health care in a health care facility, the revocation must be communicated to your attending physician).
- by completing a new advance directive for health care. A new advance directive will revoke an older advance directive to the extent that they are inconsistent with each other.

#### Change in Marital Status

If you get married after completing your advance directive for health care and you have not named your spouse as your health care agent, your marriage automatically revokes the power of your health care agent. If you have appointed your spouse as your health care agent and you divorce or the marriage is annulled, your health care agent's power is automatically revoked. You can, however, specify that you do not want these changes to occur in section 8 in PART TWO of your advance directive for health care.

### **What other important facts should I know?**

#### Pregnancy

If you are a woman and would like your treatment preferences regarding withholding or withdrawal of life-sustaining procedures, nourishment, or hydration to be honored even if you are pregnant, you must initial the statement in section 9 in PART TWO of the advance directive for health care form.

State law requires that, before honoring a pregnant patient's Treatment Preferences, the attending physician must first determine whether the fetus is viable. If the fetus is viable, your treatment preferences will not be honored, even if you initial section 9.

#### Guardianship

Part III of your advance directive for health care provides space where you can nominate someone to serve as your guardian if there should come a time when you need a court-appointed guardian. Unless a court specifies otherwise, your guardian has no power to make any personal or health care decisions granted to your agent under your advance directive for health care.

INSTRUCTIONS

PRINT YOUR NAME  
AND BIRTH DATE

INTRODUCTION

**GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE - PAGE 1 OF 12**

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By: \_\_\_\_\_  
(Print Name)

Date of Birth: \_\_\_\_\_  
(Month/Day/Year)

This advance directive for health care has four parts:

**PART ONE: HEALTH CARE AGENT.** This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.

**PART TWO: TREATMENT PREFERENCES.** This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.

**PART THREE: GUARDIANSHIP.** This part allows you to nominate a person to be your guardian should one ever be needed.

**PART FOUR: EFFECTIVENESS AND SIGNATURES.** This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care may be used in Georgia.

You may revoke this completed form at any time.

Once completed, this form will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form.

INSTRUCTIONS

PRINT THE NAME AND ADDRESS OF YOUR HEALTH CARE AGENT

PRINT NAMES, ADDRESSES, AND TELEPHONE NUMBERS OF YOUR ALTERNATE HEALTH CARE AGENTS

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**PART ONE: HEALTH CARE AGENT**

*[PART ONE will be effective even if PART TWO is not completed. A physician or health care provider who is directly involved in your health care may not serve as your health care agent. Unless you specify otherwise in section 8 of PART TWO, if you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your health care agent. Unless you specify otherwise in section 8 of PART TWO, if you are not married, a future marriage will revoke the selection of your health care agent unless the person you selected as your health care agent is your new spouse.]*

**(1) HEALTH CARE AGENT**

I select the following person as my health care agent to make health care decisions for me:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

(Home, Work, and Mobile)

**(2) BACK-UP HEALTH CARE AGENT**

*[This section is optional. PART ONE will be effective even if this section is left blank.]*

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

(Home, Work, and Mobile)

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

(Home, Work, and Mobile)



INSTRUCTIONS

DESCRIPTION OF  
POWERS OF  
HEALTH CARE  
AGENT

**(3) GENERAL POWERS OF HEALTH CARE AGENT**

My health care agent will make health care decisions for me when I am unable to make my health care decisions or I choose to have my health care agent make my health care decisions. My health care agent will have the same authority to make any health care decision that I could make.

My health care agent's authority includes, for example, the power to:

- Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- Request, consent to, withhold, or withdraw any type of health care; and
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that, under Georgia law:

- My health care agent may refuse to act as my health care agent;
- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and
- My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.

**(4) GUIDANCE FOR HEALTH CARE AGENT**

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

INSTRUCTIONS

INITIAL IF YOU DO NOT WANT YOUR HEALTH CARE AGENT TO HAVE POWER TO AUTHORIZE AN AUTOPSY

INITIAL STATEMENTS THAT YOU WANT TO APPLY, IF ANY

INITIAL HERE IF YOU WANT SOMEONE OTHER THAN YOUR HEALTH CARE AGENT TO MAKE FINAL DISPOSITION DECISIONS

INITIAL THE ONE STATEMENT THAT REFLECTS YOUR WISH

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(5) POWERS OF HEALTH CARE AGENT AFTER DEATH

(A) AUTOPSY

My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent's power by initialing below.

\_\_\_\_\_ (Initials) My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) ORGAN DONATION AND DONATION OF BODY

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless I have limited my health care agent's power by initialing below.

[Initial each statement that you want to apply.]

\_\_\_\_\_ (Initials) My health care agent will not have the power to make a disposition of my body for use in a medical study program.

\_\_\_\_\_ (Initials) My health care agent will not have the power to donate any of my organs.

(C) FINAL DISPOSITION OF BODY

My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

\_\_\_\_\_ (Initials) I want the following person to make decisions about the final disposition of my body:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

(Home, Work, and Mobile)

I wish for my body to be:

\_\_\_\_\_ (Initials) Buried

OR

\_\_\_\_\_ (Initials) Cremated

**PART TWO: TREATMENT PREFERENCES**

*[PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.]*

**(6) CONDITIONS**

PART TWO will be effective if I am in any of the following conditions:

*[Initial each condition in which you want PART TWO to be effective.]*

\_\_\_\_\_ (Initials) A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

\_\_\_\_\_ (Initials) A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

My condition will be certified in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

INITIAL THE STATEMENTS THAT REFLECT YOUR WISH

YOU MAY INITIAL BOTH STATEMENTS

**(7) TREATMENT PREFERENCES**

*[State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, regardless of which choice you make, but you may also want to state your specific preferences regarding pain relief in the next section.]*

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A) \_\_\_\_\_ (Initials) Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

OR

(B) \_\_\_\_\_ (Initials) Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

OR

(C) \_\_\_\_\_ (Initials) I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:

*[Initial each statement that you want to apply to option (C).]*

\_\_\_\_\_ (Initials) If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.

\_\_\_\_\_ (Initials) If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.

\_\_\_\_\_ (Initials) If I need assistance to breathe, I want to have a ventilator used.

\_\_\_\_\_ (Initials) If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

INITIAL ONE  
STATEMENT THAT  
REFLECTS YOUR  
WISH

INITIAL ONLY ONE  
(A, B, OR C)

IF YOU INITIAL (C),  
INITIAL EACH  
STATEMENT THAT  
YOU WANT TO  
APPLY

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INSTRUCTIONS

OPTIONAL SECTION

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

**(8) ADDITIONAL STATEMENTS**

*[This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.]*

Multiple horizontal lines for writing additional statements.

**(9) IN CASE OF PREGNANCY**

*[PART TWO will be effective even if this section is left blank.]*

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

\_\_\_\_\_ (Initials) I want PART TWO to be carried out if my fetus is not viable.

INITIAL HERE IF  
YOU WANT PART  
TWO TO BE  
CARRIED OUT IF  
YOU ARE PREGNANT  
AND YOUR FETUS IS  
NOT VIABLE

**PART THREE: GUARDIANSHIP**

**(10) GUARDIANSHIP**

*[PART THREE is optional. This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.]*

*[State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.]*

(A) \_\_\_\_\_ (Initials) I nominate the person serving as my health care agent under PART ONE to serve as my guardian.

OR

(B) \_\_\_\_\_ (Initials) I nominate the following person to serve as my guardian:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_

(Home, Work, and Mobile)

INITIAL YOUR PREFERENCE REGARDING NOMINATION OF YOUR GUARDIAN, IN THE EVENT YOU NEED TO HAVE ONE APPOINTED BY A COURT

INSTRUCTIONS

**PART FOUR: EFFECTIVENESS AND SIGNATURES**

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

\_\_\_\_\_ (Initials) This advance directive for health care will become effective on or upon \_\_\_\_\_ and will terminate on or upon \_\_\_\_\_.

*[You must sign and date or acknowledge signing and dating this form in the presence of two witnesses.*

*Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.*

*A witness cannot be:*

- *A person who was selected to be your health care agent or back-up health care agent in PART ONE;*
- *A person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or*
- *A person who is directly involved in your health care.*

*Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).]*

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

\_\_\_\_\_  
(Signature of Declarant) (Date)

INITIAL HERE IF YOU WANT TO LIMIT WHEN THIS ADVANCE DIRECTIVE IS EFFECTIVE

SIGN AND DATE

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INSTRUCTIONS

HAVE YOUR  
WITNESSES SIGN,  
DATE AND PRINT  
THEIR ADDRESSES  
HERE

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

\_\_\_\_\_  
(Signature of witness) (Date)

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
(Signature of witness) (Date)

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

*[This form does not need to be notarized.]*

## You Have Filled Out Your Health Care Directive, Now What?

1. Your *Georgia Advance Directive for Health Care* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your Georgia document.
7. Be aware that your Georgia document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

## Congratulations!

You've downloaded **your free, state specific advance directive**.

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and CaringInfo allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

**I hope you will show your support for our mission and make a tax-deductible gift today.**

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of \$23, \$47, \$64**, or the most generous amount you can send.

**You can help** us provide resources like this advance directive FREE by sending in your gift to help others.

**Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.**



**YES!** I want to support the important work of the National Hospice Foundation.

- |      |  |
|------|--|
| \$23 | helps us provide free advance directives           |
| \$47 | helps us maintain our free InfoLine                |
| \$64 | helps us provide webinars to hospice professionals |

Return to:  
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AD\_2016



OR donate online today: [www.caringinfo.org/donate](http://www.caringinfo.org/donate)