Puerto Rico
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
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800/658-8898

CARINGINFO

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:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage 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.**

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may 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 Puerto Rico Advance Directive

This packet contains a *Puerto Rico Advanced Statement of Will Regarding Treatment*, which protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself. You may complete Part I or Part II depending on your advance planning needs, but you must complete Part III if you compete either Part I or Part II. You may also complete Part IV.

Part I, **Designation and Powers of My Executor**, lets you name someone, your "executor," to make decisions about your health care—including decisions about life-prolonging procedures—if you can no longer speak for yourself.

Part I goes into effect when your physician diagnoses you with a terminal health condition or determines that you are in a persistent vegetative state.

Part II, **My Health Care Instructions**, lets you state your wishes about health care in the event you cannot speak for yourself.

Part II goes into effect when your physician diagnoses you with a terminal health condition or determines that you are in a persistent vegetative state.

Part III contains the signature and witnessing provisions so that your document will be effective.

Note: Parts I, II, and III will be legally binding only if the person completing it is a competent adult (at least 21 years old).

Part IV allows you to record your organ and tissue donation wishes.

Note: Part IV will be legally binding only if the person completing it is at least 18 years old.

This form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about an advance directive tailored to your needs.

Completing Your Puerto Rico Advance Directive

How do I make my *Puerto Rico Advanced Statement of Will Regarding Treatment* legal?

You must sign and date your advance directive in the presence of a physician and two witnesses who are at least 21 years old. The physician and your two witnesses cannot be your heirs or participants in your direct care.

In the alternative, you may sign and date your advance directive in the presence of a notary. The notary cannot be related to you or a beneficiary under your will.

Whom should I appoint as my executor?

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

You can appoint a second person as your alternate executor. The alternate will step in if the first person you name as executor is unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my *Puerto Rico Advanced Statement of Will Regarding Treatment*?

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

What if I change my mind?

If you wish to make any changes or modifications to your *Puerto Rico Advanced Statement of Will Regarding Treatment*, you must create a new advance directive and fulfill all of the same requirements.

You may revoke your *Puerto Rico Advanced Statement of Will Regarding Treatment* in its totality at any time by writing or verbally stating your intent to revoke. If your revocation is in writing, it must contain your express will to revoke the provisions in your advance directive, your signature, and the date of the revocation. You must inform your physician that you revoked your advance directive.

What other important facts should I know?

You may not limit treatments needed to alleviate your pain or to hydrate and feed you *unless* your death is imminent and/or your body can no longer absorb the nutrients and hydration administered.

If you are pregnant, your advance directive will not be effective.

Puerto Rico Advanced Statement of Will Regarding Treatment

PRINT YOUR NAME

I, _____, willingly and voluntarily make known my wishes in the event that I am incapable of making an informed decision about my health care and I have been diagnosed with a terminal health condition or I am permanently unconscious, as follows in this document.

This Advanced Statement of Will Regarding Treatment shall not terminate in the event of my disability.

PART I: DESIGNATION OF EXECUTOR

(CROSS THROUGH AND INITIAL IF YOU DO NOT WANT TO APPOINT AN EXECUTOR TO MAKE HEALTH CARE DECISIONS FOR YOU)

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY EXECUTOR

I hereby appoint _____,
(primary executor)
of _____

_____
(address and telephone number)

as my executor to make health care decisions on my behalf as authorized in this document. If the person I have appointed above is not reasonably available or is unable or unwilling to act as my executor, then I appoint

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE EXECUTOR

_____,
(alternate executor)
of _____

_____,
(address and telephone number)
to serve in that capacity.

I grant to my executor, named above, full power and authority to make health care decisions on my behalf, as described below, whenever I have been determined to be incapable of making an informed decision, and I have been diagnosed with a terminal health condition or I am permanently unconscious. My executor's authority hereunder is effective as long as I am incapable of making an informed decision.

In making health care decisions on my behalf, I want my executor to follow my desires and preferences as stated in this document or as otherwise known to him or her. If my executor cannot determine what health care choice I would have made on my own behalf, then I want my executor to make a choice for me based upon what he or she believes to be in my best interests.

POWERS OF YOUR EXECUTOR

LIST ANY SPECIFIC POWERS THAT YOU WANT YOUR EXECUTOR TO HAVE OR ANY LIMITATIONS ON THE POWER OF YOUR EXECUTOR WITH REGARD TO YOUR MEDICAL TREATMENT

ATTACH ADDITIONAL PAGES IF NEEDED

POWERS OF MY EXECUTOR

The powers of my executor shall include the following:

(attach additional pages if needed)

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

I give the following instructions to further guide my executor in making health care decisions for me:

(attach additional pages if needed)

PART II: HEALTH CARE INSTRUCTIONS

HEALTH CARE INSTRUCTIONS

You may use any or all of Parts A, B, or C in this section to direct your health care even if you do not have an executor. If you choose not to provide written instructions, decisions will be based on your values and wishes, if known, and otherwise in your best interests.

A. Instructions If I have a Terminal Health Condition

I provide the following instructions in the event my attending physician determines that I have a terminal health condition and medical treatment will not help me recover:

INITIAL ONLY ONE

____ I do not want any treatments to prolong my life. This includes, but is not limited to, tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), dialysis or antibiotics. I understand that I still will receive medical treatments needed to alleviate my pain or to hydrate and feed me unless my death is imminent (very close) and/or my body can no longer absorb the nutrients and hydration administered

OR

____ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable.

OR

YOU MAY WRITE HERE YOUR OWN INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE DYING, INCLUDING SPECIFIC INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT.

IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE

ATTACH ADDITIONAL PAGES IF NEEDED

____ I direct the following regarding health care when I am dying:

_____
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(attach additional pages if needed)

INITIAL ONLY ONE

YOU MAY WRITE HERE YOUR INSTRUCTIONS ABOUT YOUR CARE WHEN YOU ARE UNABLE TO INTERACT WITH OTHERS AND ARE NOT EXPECTED TO RECOVER THIS ABILITY.

THIS INCLUDES SPECIFIC INSTRUCTIONS ABOUT TREATMENTS YOU DO WANT, IF MEDICALLY APPROPRIATE, OR DON'T WANT. IT IS IMPORTANT THAT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE

ATTACH ADDITIONAL PAGES IF NEEDED

B. Instructions if I am in a Persistent Vegetative State

I provide the following instructions if my condition makes me unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover this awareness or ability even with medical treatment:

____ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis, or antibiotics. I understand that I still will receive medical treatments needed to alleviate my pain or to hydrate and feed me unless my death is imminent (very close) and/or my body can no longer absorb the nutrients and hydration administered

OR

____ I want all treatments to prolong my life as long as possible within the limits of generally accepted health care standards. I understand that I will receive treatment to relieve pain and make me comfortable.

OR

____ I want to try treatments for a period of time in the hope of some improvement of my condition. I suggest _____ (insert time period) as the period of time, after which such treatment should be stopped if my condition has not improved. The exact time period is at the discretion of my executor or surrogate in consultation with my physician. I understand that I still will receive treatment to relieve pain and make me comfortable.

OR

____ I direct the following regarding when I am unaware of myself or my surroundings or unable to interact with others, and it is reasonably certain that I will never recover this awareness or ability even with medical treatment:

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(attach additional pages if needed)

YOU MAY WRITE HERE STATEMENTS AND INSTRUCTIONS ABOUT TREATMENTS THAT YOU DO WANT, IF MEDICALLY APPROPRIATE, OR ABOUT TREATMENTS YOU DO NOT WANT UNDER SPECIFIC CIRCUMSTANCES OR ANY CIRCUMSTANCES.

IT IS IMPORTANT YOUR INSTRUCTIONS HERE DO NOT CONFLICT WITH OTHER INSTRUCTIONS YOU HAVE GIVEN IN THIS ADVANCE DIRECTIVE

THESE INSTRUCTIONS CAN 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

C. Other Instructions Regarding My Health Care

I further direct the following regarding my health care when I am incapable of making my own health care decisions:

(attach additional pages if needed)

I understand that Puerto Rico statutes specify that if I am discovered to be pregnant at the time I am diagnosed with a terminal health condition or I am in a persistent vegetative state, any refusal of life sustaining medical treatment must be postponed until the pregnancy has ended.

PART III: EXECUTION

Alternative No. 1: Sign Before a Physician and Two Witnesses

Affirmation: By signing below, I indicate that I am 21 years of age or older and of sound mind, and that it is my right to make this Advanced Statement of Will Regarding Treatment and that I understand the purpose and effect of this document. It is my express will that the physician or health service institution that is in charge of my care while I am suffering a terminal health condition or I am in a persistent vegetative state follow my instructions or those of my named executor. I understand that I may revoke this document at any time.

SIGN, DATE, AND PRINT YOUR NAME HERE

_____

(signature of declarant) (date)

_____

(printed name)

A PHYSICIAN AND YOUR TWO WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES AND THE LOCATION HERE

The declarant voluntarily signed the foregoing Advanced Statement of Will Regarding Treatment in my presence. I attest that I do not participate in the direct care of the declarant, nor am I the declarant's heir.

Physician Signature_____ Date_____

Printed name _____ Location_____

Witness Signature _____ Date_____

Printed name _____ Location_____

Witness Signature _____ Date_____

Printed name _____ Location_____

SIGN, DATE, AND PRINT YOUR NAME HERE

A NOTARY SHOULD COMPLETE THIS SECTION OF YOUR DOCUMENT

Alternative No. 2: Sign Before a Notary Public

Affirmation: By signing below, I indicate that I am 21 years of age or older and of sound mind, and that it is my right to make this Advanced Statement of Will Regarding Treatment and that I understand the purpose and effect of this document. It is my express will that the physician or health service institution that is in charge of my care while I am suffering a terminal health condition or I am in a persistent vegetative state follow my instructions or those of my named executor. I understand that I may revoke this document at any time.

_____

(signature of declarant) (date)

_____

(printed name)

Commonwealth of Puerto Rico,

County/Municipality: _____ }

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence (describe:_____)) to be the person(s) whose name(s) is/are subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed. I am not the agent, executor, proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

_____ **Notary Seal:**

Signature of Notary Public/Authenticator

_____

Date Commission Expires

PART IV: ORGAN DONATION

IF YOU WISH TO DONATE YOUR ORGANS, EYES, OR TISSUES, INITIAL THE OPTION THAT REFLECTS YOUR WISHES

You may record your decision to donate your organs, eyes, and tissues, or your whole body after your death. If you do not make this decision here or in any other document, your executor or surrogate may make the decision for you unless you specifically prohibit him or her from doing so, which you may do in this or some other document.

_____I donate my organs, eyes, and tissues for use in transplantation, therapy, research and education. I direct that all necessary measures be taken to ensure the medical suitability of my organs, eyes, or tissues for donation;

OR

_____I donate my whole body for research and education.

INSERT ANY SPECIFIC INSTRUCTIONS YOU WISH TO GIVE ABOUT ANATOMICAL GIFTS, IF ANY

ATTACH ADDITIONAL PAGES IF NECESSARY

I direct the following regarding donation of my organs, eyes, and tissues:

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(attach additional pages if needed)

Alternative No. 1: Sign Before Two Witnesses

Affirmation: By signing below, I indicate that I am 18 years of age or older and of sound mind, and that it is my right to make this statement regarding organ donation. It is my express will that the physician or health service institution that is in charge of my care, my executor, or any other surrogate decision maker follow my instructions. I understand that I may revoke this document at any time.

SIGN, DATE, AND PRINT YOUR NAME HERE

_____

(signature of declarant) (date)

_____

(printed name)

The declarant voluntarily signed the foregoing statement regarding organ donation in my presence.

YOUR TWO WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES HERE

Witness Signature _____ Date_____

Printed name _____ Location_____

Witness Signature _____ Date_____

Printed name _____ Location_____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

Alternative No. 2: Sign Before a Notary Public

Affirmation: By signing below, I indicate that I am 18 years of age or older and of sound mind, and that it is my right to make this statement regarding organ donation. It is my express will that the physician or health service institution that is in charge of my care, my executor, or any other surrogate decision maker follow my instructions. I understand that I may revoke this document at any time.

SIGN, DATE, AND PRINT YOUR NAME HERE

_____

(signature of declarant) (date)

_____

(printed name)

Commonwealth of Puerto Rico,

County/Municipality: _____ }

A NOTARY SHOULD COMPLETE THIS SECTION OF YOUR DOCUMENT

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence (describe:_____)) to be the person(s) whose name(s) is/are subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed. I am not the agent, executor, proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

_____ **Notary Seal:**

Signature of Notary Public/Authenticator

_____

Date Commission Expires

Courtesy of CaringInfo
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www.caringinfo.org, 800/658-8898

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

1. Your *Puerto Rico Advanced Statement of Will Regarding Treatment* 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 executor and alternate executor, physician(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 executor(s), physician(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 Puerto Rico document.

7. Be aware that your Puerto Rico 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 these 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

Return to:
National Hospice Foundation
PO Box 824401
Philadelphia, PA 19182-4401

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OR donate online today: www.caringinfo.org/donate