PUERTO RICO
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
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 and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your territory-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 21 years of age or older.

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, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare 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 your electronic healthcare record, or 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 HEALTH CARE 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.

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

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

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.

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.

How do I make my Puerto Rico Advance Health Care Directive 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 agent?

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

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Part I, **Designation and Powers of My Executor,** 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**, goes into effect when your physician diagnoses you with a terminal health condition or determines that you are in a persistent vegetative state.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

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, and your agent will be bound by the current laws of Puerto Rico as they regard pregnancy and termination of pregnancies.

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.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

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

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

POWERS OF MY EXECUTOR

The powers of my executor shall include the following:

(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)

HEALTH CARE INSTRUCTIONS

PART II: 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

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

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

(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:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(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_____

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.

SIGN, DATE, AND PRINT YOUR NAME HERE

_____

(signature of declarant) (date)

_____

(printed name)

Commonwealth of Puerto Rico,

A NOTARY SHOULD COMPLETE THIS SECTION OF YOUR DOCUMENT

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:

(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
www.caringinfo.org

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,

A NOTARY SHOULD COMPLETE THIS SECTION OF YOUR DOCUMENT

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