Legal Forms & Services

FirstName LastName

TENNESSEE
HEALTH CARE DIRECTIVE

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The answers you provide in the questionnaire are incorporated in this document at your direction. The form was developed by attorneys based on the laws of your state. You are responsible for finalizing the document and having it reviewed by an attorney.

Finalizing a Health Care Directive in Tennessee
After printing your document, you will need to finalize it. Below are the steps:

Option 1: Witnesses Only
1. Print out your document
2. Review, initial, sign, and date in front of two witnesses
3. Have witnesses sign and date
4. Keep document in a safe place

Option 2: Notary Only
1. Print out your document
2. Review, initial, sign, and date in front of a notary
3. Have notary sign and date
4. Keep document in a safe place

Notice: Some state laws require the principal to initial next to the instructions they have provided in order for that instruction to be effective. Review the state laws applicable to and health care directives, review the document carefully, and initial where required by law.

Some state laws prohibit the designation of certain people as a health care agent. To avoid that result, you should review your state laws applicable to who can and cannot be a health care agent.

Some state laws prohibit certain people from being witnesses to a health care directive. Review your state's laws on witness requirements for health care directives.

LIVING WILL

FOR

FirstName LastName

I, FirstName LastName, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

PRIMARY HEALTH CARE AGENT: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name:	FirstName LastName
Relationship:	Spouse
Address:	111 Street Address
	City, Tennessee 11111
Phone:	1111111111
Email:	emailaddress@email.com

ALTERNATE HEALTH CARE AGENT: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name:	FirstName LastName
Relationship:	Son
Address:	222 Street Address
	City, Tennessee 11111
Phone:	1111111111
Email:	emailaddress@email.com

WHEN EFFECTIVE: I give my agent authority to make health care decisions for me when I no longer have capacity.

AUTHORITY OF HEALTH CARE AGENT: My health care agent must follow my health care instructions in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest. Generally, my agent's authority includes the following:

- The same rights that I would have to request, receive, examine, copy, and consent to the disclosure of medical or other health care information.
- Consent or refuse to consent to care, treatment, service, or procedures
- Select or discharge health care providers
- Approve or disapprove proposed tests, surgical procedures, and medication
- Direct the provision, withholding, or withdrawal of medical care and treatment for the purpose of sustaining life, including artificial nutrition and hydration and pain relief medication and treatment
- Make an anatomical gift following my death

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

LIMITATIONS ON HEALTH CARE AGENT'S AUTHORITY:

I do not wish to limit the authority of my health care agent at this time.

PART 2: HEALTH CARE INSTRUCTIONS

WISHES FOR QUALITY OF LIFE: BY MARKING "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an unacceptable quality of life).

☐ Yes ☑ No	**Permanent Unconscious Condition:** If I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☑ No	**Permanent Confusion.** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes ☑ No	**Dependent in All Activities of Daily Living.** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☑ No	**End-Stage Illnesses.** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged

	heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

WISHES FOR TREATMENT: I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I do not want.

☐ Yes ☑ No	**CPR (Cardiopulmonary Resuscitation):** To make the heartbeat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☑ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes ☑ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☑ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

PART 3: OTHER INSTRUCTIONS

I do not wish to leave additional instructions at this time.

PART 4: ORGAN DONATION

Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

☐ Any organ/tissue

☑ My entire body

☐ Only the following organs/tissue:

☐ No organ/tissue donation

SIGNATURES

This document must be signed and dated by me. It also must either be verified by two witnesses (Option 1) OR a notary public (Option 2). It must be signed and dated when it is witnessed or verified.

I, FirstName LastName, sign this directive voluntarily and declare I am capable of understanding the instructions I have given and the choices I have made therein. I understand that I may revoke this directive at any time prior to my incapacity.

My Signature: ______________________________

Date signed: _______________________________

TWO WITNESSES (OPTION 1)

Witness One. In my presence on ___________________________ (date), FirstName LastName (name) acknowledged his/her/their signature on this document. I certify the following:

- I am a competent adult.
- I am not named as a health care agent or an alternate health care agent in this document.

Witness One Signature: ____________________________

Witness One Printed Name: _________________________

Witness One Address: ______________________________

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Witness One Phone: ________________________________

Witness Two. In my presence on ___________________________ (date), FirstName LastName (name) acknowledged his/her/their signature on this document. I certify the following:

- I am a competent adult.
- I am not named as a health care agent or an alternate health care agent in this document.

- I am not related to the principal by blood, marriage, or adoption.
- I am not entitled to any portion of the estate of the principal upon the death of the principal under any will or codicil made by the principal or by operation of law.

Witness Two Signature: ____________________________

Witness Two Printed Name: _________________________

Witness Two Address: _____________________________

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Witness Two Phone: _______________________________

OR

NOTARY PUBLIC (OPTION 2)

In my presence on ___________________________ (date), FirstName LastName (name) acknowledged his/her/their signature on this document or acknowledged that he/she/they authorized the person signing this document to sign on his/her/their behalf.

Notary Public Signature: _________________________________

Commission Expiration Date: _____________________________