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Legal Forms & Services

FirstName LastName

RHODE ISLAND 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 Rhode Island

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 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

This document includes the following:

Declaration relating to the use of life sustaining procedures to guide those making health care decisions on my behalf in the event I am unable to communicate or make my health care decisions on my own.

Health care power of attorney designating a health care agent to make my health care decisions based on these instructions if I am unable to speak or make them myself. If my wishes are unknown, my health care agent should act in my best interest.

PART I: DECLARATION

I, FirstName LastName, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If I should have an incurable or irreversible condition that will cause my death and if I am unable to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort, or to alleviate pain.

This authorization

☑ includes

☐ does not include

the withholding or withdrawal of artificial feeding (check only one box).

PART II: HEALTH CARE POWER OF ATTORNEY

DESIGNATION OF HEALTH CARE AGENT. I, FirstName LastName, do hereby designate and appoint as my health care agent:

Name: FirstName LastName

Relationship: Spouse

Address: 111 Street Address

City, Rhode Island 11111

Phone: 1111111111

Email: emailaddress@email.com

DESIGNATION OF ALTERNATE AGENTS. If the person designated as my agent above is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

First Alternate Agent.

Name: FirstName LastName

Relationship: Son

Address: 222 Street Address

City, Rhode Island 11111

Phone: 1111111111

Email: emailaddress@email.com

GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment,

services, and procedures and informing my family or next of kin of my desire, if any, to be an organ or tissue donor.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

(a) Statement of desires concerning life-prolonging care, treatment, services, and procedures: I do not have a statement of desires at this time.

(b) Additional statement of desires, special provisions, and limitations regarding health care decisions: I do not have an additional statement of desires, special provisions, or limitations at this time.

(c) Statement of desire regarding organ and tissue donation: I wish to donate my organs and tissue.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital or physician.

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, is personally known to me to be the principal, and appears to be of sound mind and under no duress, fraud, or undue influence. I certify the following:

- I am not named as a health care agent or an alternate health care agent in this document.
- I am not the principal's health care provider, or a non-relative employee of principal's health care provider.
- I am not the operator of a community care facility, or a non-relative employee of a community care facility where the principal is receiving treatment.

Witness One Signature: _____

Witness One Printed Name: _____

Witness One Address: _____

_____

Witness One Phone: _____

Witness Two In my presence on _____ (date), FirstName LastName (name) acknowledged his/her/their signature on this document, is personally known to me to be the principal, and appears to be of sound mind and under no duress, fraud, or undue influence. I certify the following:

- I am not named as a health care agent or an alternate health care agent in this document.
- I am not the principal's health care provider, or a non-relative employee of principal's health care provider.
- I am not the operator of a community care facility, or a non-relative employee of a community care facility where the principal is receiving treatment.
- I am not related to the principal by blood, marriage, or adoption.
- To the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Witness Two Signature: _____

Witness Two Printed Name: _____

Witness Two Address: _____

_____

Witness Two Phone: _____

OR

NOTARY PUBLIC (OPTION 2)

In my presence on _____ (date), FirstName LastName (name) acknowledged his/her/their signature on this document.

- I am not related to the principal by blood, marriage, or adoption.
- To the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Notary Public Signature: _____

Commission Expiration Date: _____