FirstName LastName

MISSISSIPPI 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 Mississippi

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:

Power of attorney for health care 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.

Instructions for health care 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.

PART 1 POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF AGENT: I, FirstName LastName, designate the following individual as my agent to make health care decisions for me:

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

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent**:**

Name:	FirstName LastName
Relationship:	Son
Address:	333 Street Address
	City, Mississippi 11111
Phone:	1111111111
Email:	emailaddress@email.com

AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:

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

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2 INSTRUCTIONS FOR HEALTH CARE

END-OF-LIFE DECISIONS: I, FirstName LastName, direct that my health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

_____☑ (a) Choice Not to Prolong Life

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, or

☐ (b) Choice To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be:

_____☑ Withheld or withdrawn

RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death: I do not wish to state exceptions to treatment for alleviation of pain or discomfort at this time.

OTHER WISHES: I direct that:

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

PART 3 PRIMARY PHYSICIAN (OPTIONAL)

I designate the following as my primary physician:

I do not wish to designate a primary physician at this time.

EFFECT OF COPY: A copy of this form has the same effect as the original.

PART 4 CERTIFICATE OF AUTHORIZATION FOR ORGAN DONATION (OPTIONAL)

I, FirstName LastName, this _ day of _____, _____ desire the following upon my demise:

_____☑ I WANT to donate any organs and tissue.

I specifically provide that this declaration shall supersede and take precedence over any decision by my family to the contrary.

SIGNATURES: Sign and date form here:

This document must be signed and dated by me. It also must either be verified by two witnesses (Alternative No. 1) OR a notary public (Alternative No. 2). It must be signed and dated when it is witnessed or verified.

_____ _____

(Date) (Signature)

_____ FirstName LastName

(Address) (Printed Name)

ALTERNATIVE NO. 1
WITNESSES

Witness One. On _____, I declare under penalty of perjury pursuant to Miss. Code Ann. § 97-9-61, that FirstName LastName, is personally known to me, that the principal signed or acknowledged this document in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence. I certify the following:

- I am not the person appointed as agent or alternate health care agent in this document.
- I am not the principal's health-care provider, nor an employee of a health-care provider or facility.

Witness One Signature: _____

Witness One Printed Name: _____

Witness One Address: _____

_____

Witness One Phone: _____

Witness Two. On _____, I declare under penalty of perjury pursuant to Miss. Code Ann. § 97-9-61, that FirstName LastName, is personally known to me, that the principal signed or acknowledged this document in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence. I certify the following:

- I am not the person appointed as agent or alternate health care agent in this document.
- I am not the principal's health-care provider, nor an employee of a health-care provider or facility.
- 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

ALTERNATIVE NO. 2
NOTARY

State of _____

County of _____

In my presence on _____ (date), appeared FirstName LastName, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument and acknowledged that he or she executed it or acknowledged this document to be signed on his or her behalf. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

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

Notary Public Signature: _____

Commission Expiration Date: _____