CONNECTICUT

Advance Directives:

Planning for Future Health Care Decisions

- Your Rights to Make Health Care Decisions and Frequently Asked Questions – A Summary of Connecticut Law
- Directions for Completing the Consolidated Health Care Instructions and Advance Directives Document
- Consolidated Health Care Instructions and Advance Directives Document including all of the Advance Directives – Appointment of A Health Care Representative, Living Will and Health Care Instructions, Appointment of A Conservator, and Organ Donation – in one form.

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
Bureau of Aging, Community and Social Work Services
Aging Services Division [State Unit on Aging]
25 Sigourney Street, Hartford, CT 06106

Aging Services Division

Connecticut Department of Social Services
Caring for Connecticut

Pub. # 06-14

Planning For Future Health Care Decisions In Connecticut: Your Health Care Planning Packet

Please find enclosed:

1. "Your Rights to Make Health Care Decisions and Frequently Asked Questions" prepared, in large part, by the Office of the Attorney General for the Connecticut Department of Social Services (FAQs pages 1 – 7);

2. Directions for Completing the Consolidated Health Care Instructions and Advance Directives Document (Directions pages 1 – 2); and the

3. Consolidated Health Care Instructions and Advance Directives Document including all of the advance directives (appointment of health care representative, living will, appointment of a conservator of the persons and organ donation) in one form (Document pages 1 – 5, 6).

Important Notes:

The Consolidated Health Care Instructions and Advance Directives Document is a legal document and gives broad legal powers to persons designated by you. If there are **any** portions of this Planning Packet that you do not understand or which may confuse you, **consult an attorney.** You may wish to contact your own attorney, or contact the Legal Services Developer at the Aging Services Division, 1-860-424-5244 or through 1-800-443-9946, relative to questions regarding this form or for a list of legal assistance resources available for older persons in Connecticut.

Numerous resources (such as your doctor or faith advisor) are also available to assist you in making decisions about end-of-life health care issues including life sustaining measures (such as artificial hydration and nutrition, cardiopulmonary resuscitation, and do-not-resuscitate orders), palliative care, quality of life, and the impact of your religious beliefs and moral convictions. Some other resources include:

National Hospice and Palliative Care Organization Helpline
800-658-8898
www.caringinfo.org; caringinfo@nhpco.org

ABA Commission on Law & Aging
Consumer Tool Kit (202) 662-8690
www.abanet.org/aging/toolkit/
abaaging@abanet.org

Cuidano con Carnio, Compassionate Care Helpline 877-658-8896
www.hispanichealth.org
cuidando@hispanichealth.org

Su Familia: The National Hispanic Family Health Helpline 866-783-2645
www.hispanichealth.org;
sufamilia@hispanichealth.org

CT Area Agencies on Aging
CHOICES HelpLine
1-800-994-9422

This information is available in alternate format. Phone (800) 842-1508 or TDD/TTY (800) 842-4524.

Your Rights to Make Health Care Decisions and Frequently Asked Questions

A Summary of Connecticut Law prepared, in large part, by the Office of the Attorney General for the CT Department of Social Services

- You have the right to make health care decisions about the medical care you receive. If you do not want certain treatments, you have the right to tell your physician you do not want them and have your wishes followed.

- You also have the right to receive information from your physician to assist you in reaching a decision about what medical care is to be provided to you.

- There may, however, come a time when you are unable to actively participate in determining your treatment due to serious illness, injury or other disability.

1. Do I have the right to make health care decisions?

Yes. Adult patients in Connecticut have the right to determine what, if any, medical treatment they will receive. If you can understand the nature and consequences of the health care decisions that you are being asked to make, you may agree to treatment that may help you or you may refuse treatment even if the treatment might keep you alive longer.

2. Do I have the right to information needed to make a health care decision?

Yes. Physicians have the responsibility to provide patients with information that can help them to make a decision. Your physician will explain:

- what treatments may help you;
- how each treatment may affect you, that is, how it can help you and what, if any, serious problems or side effects the treatment is likely to cause;
- what may happen if you decide not to receive treatment.

Your physician may also recommend what, if any, treatment is medically appropriate, but the final decision is yours to make. All of this information is provided so you can exercise your right to decide your treatment wisely.

3. What is an "advance directive"?

An "advance directive" is a legal document through which you may provide your directions or express your preferences concerning your health care and/or to appoint someone to act on your behalf. Physicians and others use them when you are unable to make or communicate your decisions about your medical treatment.

Advance directives are prepared before any condition or circumstance occurs that causes you to be unable to actively make a decision about your health care.

In Connecticut, advance directives include:

- the living will and health care instructions
- the appointment of a health care representative

4. Must I have an advance directive?

No. You do not have to make a living will or other type of advance directive to receive medical care or to be admitted to a hospital, nursing home or other health care facility. No person can be denied medical care or admission based on whether they have signed a living will or other type of advance directive.

If someone refuses to provide you medical care or admit you unless you sign a living will or other type of advance directive, contact the Department of Public Health in Hartford, Connecticut at 860-509-7400.

5. What is a “living will”?

A “living will” is a document that may state your wishes regarding any kind of health care you may receive. Should you be in a terminal condition or permanently unconscious, the living will can also tell your physician whether you want "life support systems" to keep you alive or whether you do not want to receive such treatment, even if the result is your death. A living will goes into effect only when you are unable to make or communicate your decisions about your medical care.

6. What does “terminal condition” and “permanently unconscious” mean?

A patient is in a "terminal condition" when the physician finds that the patient has a condition which is (1) incurable or irreversible and (2) will result in death within a relatively short time if life support systems are not provided. "Permanently unconscious" means a permanent coma or persistent vegetative state where the patient is not aware of himself or his surroundings and is unresponsive.

7. What is a “life support system”?

A "life support system" is a form of treatment that only delays the time of your death or maintains you in a state of permanent unconsciousness. Life support systems may, among other things, include:

- devices such as respirators and dialysis;
- cardiopulmonary resuscitation (CPR);
- food and fluids supplied by artificial means, such as feeding tubes and intravenous fluids.

It **does not** include:

- normal means of eating and drinking, such as eating with assistance of another person or through a straw; or
- medications that help manage pain.

8. Will I receive medication for pain if I have a living will?

Yes. A living will does not affect the **requirement** that your doctor provide you with pain medication or care designed solely to maintain your physical comfort (for example, care designed to maintain your circulation or the health of your skin and muscles). This type of care **must** be provided whenever appropriate.

9. What is a "health care representative"?

A "health care representative" is a person whom you authorize in writing to make any and all health care decisions on your behalf including the decision whether to withhold or withdraw life support systems. **A health care representative does not act unless you are unable to make or communicate your decisions about your medical care.** The health care representative will make decisions on your behalf based on your wishes, as stated in a living will or as otherwise known to your health care representative. In the event your wishes are not clear or a situation arises that you did not anticipate, your health care representative would make a decision in your best interests, based upon what is known of your wishes.

10. What kind of treatment decisions can be made by a health care representative?

A health care representative can make any and all health care decisions for you, including the decision to accept or refuse any treatment, service or procedure used to diagnose or treat any physical or mental condition. The health care representative can also make the decision to provide, withhold or withdraw life support systems. The health care representative cannot make decisions for certain specific treatments which by law have special requirements.

11. How will my health care representative know when to get involved in making decisions for me?

At any time after you appoint your health care representative, your health care representative can ask your attending physician to provide written notice if your physician finds that you are unable to make or communicate your decisions about your medical care. Even if your health care representative does not do so, your health care providers will usually seek out your health care representative once they determine that you are unable to make or communicate your decisions about your medical care.

12. What is a "conservator of the person"?

A "conservator of the person" is someone appointed by the Probate Court when the Court finds that a person is incapable of caring for himself/herself including the inability to make decisions about his or her medical care. A person who is conserved by a court is known as a "ward".

The conservator of the person is responsible for making sure that the ward's health and safety needs are taken care of and generally also has the power to give consent for the ward's medical care, treatment and services.

If a conservator is later appointed for you, he or she must follow your health care instructions, either as expressed in a living will or as otherwise known to your conservator, made while you were able to make and communicate health care decisions. Further, a conservator cannot revoke your advance directives without a probate court order.

13. How are decisions made if I have both a health care representative and a conservator?

Generally, the decision of a health care representative will be followed if the conservator and health care representative disagree unless the probate court orders otherwise. This rule may not apply when the conservator has been appointed in some particular situations.

14. What advance directives should I have?

If you want to be sure that your wishes about your medical care are known if you cannot express them yourself, you should have a living will and you should also appoint a health care representative. Each of these advance directives has a special importance.
If you are unable to make or communicate your preferences as to your medical care, your physician will likely look first to your living will as the source of your wishes. Your health care representative can make decisions on your behalf according to what is stated in your living will. In situations that are not addressed by your living will, your health care representative can make a decision in your best interests consistent with what is known of your wishes.

15. Who can I name as my health care representative or as my conservator?

If you wish to, you can name the same person to be your health care representative and to be your conservator (should one become necessary). The following persons **cannot** be named your health care representative:

- your physician;
- if you are a patient at a hospital or nursing home or if you have applied for admission, the operators, administrators, and employees of the facility; and
- an administrator or employee of a government agency responsible for paying for your medical care.

Other than these restrictions, you can name anyone you feel is appropriate to serve as your health care representative. Of course, you should speak to the person whom you intend to name and be sure of his or her willingness to serve and to act on your wishes.

16. Do I need a lawyer to create an advance directive?

No. You do not need a lawyer to create an advance directive. You can use the forms attached.

17. Do I need a notary to create an advance directive?

Except for the optional form, the form necessary to create your advance directive does not require the use of a notary. An additional optional form (witnesses' affidavit) requires a notary public or a lawyer to verify the signature of the witnesses. This form is discussed in more detail in the next section. If you have legal questions, you should consult a lawyer.

18. Do I have to sign my advance directives in front of witnesses?

Yes. You must sign the document in the presence of two witnesses in order for the advance directives to be valid. The witnesses then sign the form.

For the living will and the appointment of health care representative, an optional form – Witnesses' Affidavit -- is provided. Although the completion of this form is not required to make the rest of your form valid, it is strongly suggested that it be completed. It is the witnesses' sworn statement that they saw you sign the living will or appointment form, that you were of sound mind and it was your free choice to do so. In the event that there is a dispute regarding your living will or appointment of a health care representative, the witnesses' affidavits support its validity and therefore the witnesses will not have to testify in person. This affidavit requires the use of an attorney or notary public. No other form requires the use of a notary or an attorney.

19. Who can witness my signature on an advance directive?

In general, Connecticut law does not state who may or may not be a witness to your advance directive. An important exception is that the person who you appoint to be your health care representative or as your conservator cannot be a witness to your signature of the appointment form.

20. Once I complete an advance directive what should I do?

You should tell the following persons that you have completed an advance directive and give them copies of the directives you have made:

- your physician;
- the person(s) you have named as a health care representative;
- anyone who will make the existence of your advance directives known if you cannot do so yourself, such as family members, close friends, your clergy or lawyer.

You should also bring copies with you when you are admitted to a hospital, nursing home or other health care facility. The copies will be made part of your medical record.

21. After I complete an advance directive, can I revoke it?

Yes. You can revoke your living will or appointment of a health care representative at any time. If you sign a new living will, it may revoke any prior living will you made. Also, you may revoke the living will portion either orally or in writing.

NOTE: To revoke the appointment of a health care representative portion, however, you must do so in writing that is observed and signed by two witnesses in order for the revocation to be valid.

Remember -- whenever you revoke an advance directive, tell your physician and others who have copies of your advance directive!

To revoke your designation of a conservator, you can do so either in writing or by making a new designation which states that earlier designations are revoked. It is advisable to put any revocation in writing. However, once a court has appointed a conservator, it cannot be revoked without a court order.

22. If I already have a living will or have appointed someone to make health care decisions, do I need a new one?

No. Connecticut's living will statutes were revised effective October 1, 2006. If your living will and other advance directives, such as a health care agent or power of attorney for health care, were completed prior to this date, they are still valid, although they are slightly different than the new advance directives.

In October 1, 2006, the health care representative replaced the appointment of a health care agent and power of attorney for health care. The health care representative is, in effect, a combination of these two types of advance directives. The new living will makes clear that the living will can be used to provide your instructions regarding any type of health care, not just life support systems.

23. If I don't have an advance directive, how will my wishes be considered if I am unable to speak for myself?

If you are unable to make and communicate your decision concerning your medical care and you do not have a living will, your physician can consult with other persons to determine what your wishes are regarding the withholding or withdrawal of life support systems. If you have discussed your wishes with your physician, he or she will, of course, know your stated wishes. Your physician may also ask your health care representative, your next of kin or close relatives and your conservator, if one has been appointed, what you have told them about your wishes regarding withholding or withdrawing life support systems. If your wishes are unknown, then decisions will be made based upon what is in your best interests.

It is not recommended that you rely on oral instructions to these individuals to make your wishes known. If there is no living will, such instructions are required to be specific and may need to be proven in a court. You are better advised to complete a living will or appoint a health care representative if you want to be sure that your wishes will be understood and known in the event you are unable to state them yourself.

24. What is a document of anatomical gift?

It is a document in which you make a gift of all or any part of your body to take effect upon death. Any adult may make an anatomical gift in writing, including through a will, a donor card or by a statement imprinted or attached to a motor vehicle operator's license. An anatomical gift may be made for the purpose of transplants, therapy, research, medical or dental education, or the advancement of medical or dental science. If you do not limit the gift's purpose to one or some of these uses, the gift can be used for any of these purposes. You may select who receives the gift - a hospital, physician, college, or an organ procurement group. You may also specify that the gift be used for transplant or therapy for a particular person. If no one is named to receive the gift, any hospital may do so.

25. Can I revoke an anatomical gift?

Yes. An anatomical gift may be revoked or changed only by (1) a signed statement; (2) an oral statement in the presence of two witnesses; (3) or by informing your physician if you are in a terminal condition. An anatomical gift may not be revoked after the donor's death.

26. What if I have more questions?

If you have additional questions about advance directives, discuss them with your physician and family. A social worker, patient representative or chaplain may be able to assist you, but they cannot provide legal advice. If you have legal questions, you should speak with a lawyer.

ADVANCE DIRECTIVE FORMS

Three sets of forms are contained in this booklet.

1. A **combined advance directive** form includes all of the advance directives- appointment of health care representative, living will, appointment of conservator and organ donation into one form. In the combined form, there is a place where you can choose to not make or use each kind of directive by signing your initials.
2. An **appointment of health care representative** form if you wish to only appoint a health care representative.
3. A **living will or health care instructions** if you wish to only make your wishes known but not appoint anyone to act on your behalf.

Each form includes the optional witness affidavit form.

Personal Requests Form

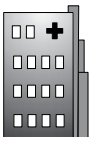
These are my personal requests, but this form is not a Will.

Name: _____

(1) Where I want to be X **Mark your choice or write in other places below.**

This is my choice about where I want to spend my final days.





☐ My Home ☐ With my family ☐ Hospital ☐ Other place _____ _____ _____

(2) How I want to be cared for

☐ Have my family and friends near.

☐ Have personal care that helps me feel comfortable.

☐ Have my favorite things around me.

☐ Have my favorite music playing.

☐ Have my religion respected.

☐ Other ways I want to be cared for:

Think about where you want your things to go and write it down.

Money _____

_____

_____

Clothing _____

Furniture

Equipment _____

Pets _____

Other _____

Personal Requests Form (page 2)

4) Gifts I want to give

Item: _____ To: _____

Item: _____ To: _____

5) Think about what you want and write it down.

☐ I want to be buried.
Where: _____

☐ I want to be cremated.
Where I want my ashes to go: _____

_____

☐ I want to donate my organs.

☐ I want to donate my body to science.

(6) Being remembered

I want a funeral service ☐ Yes ☐ No

☐ At my place of worship _____

☐ At a funeral home _____

☐ Other place _____

☐ I want people to remember me by doing this:

_____

Sign your name Date

Street address City State ZIP Code

Home phone Work phone Email

COMBINED ADVANCE DIRECTIVES

FORM

ADVANCE DIRECTIVES OF _____

To Any Physician Who Is Treating Me, this document contains the following:

1. My Appointment of A Health Care Representative
2. My Living Will or Health Care Instructions
3. My Document of Anatomical Gift
4. The Designation of My Conservator Of The Person For My Future Incapacity

As my physician, you may rely on these health care instructions and decisions made by my health care representative or conservator of my person, if I am unable to make a decision for myself.

I choose not to appoint a health care representative, please go to the next page. ____ (Initial here)

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint _____ to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, **my health care representative is authorized to (1) accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, such as psychosurgery or shock therapy as defined in Conn. Gen. Stat. § 17a-540, and (2) make the decision to provide, withhold or withdraw life support systems**.

I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

If _____ is unwilling or unable to serve as my health care representative, I appoint _____ to be my alternative health care representative.

I further instruct that as required by law my attending physician disclose to my health care representative protected health information regarding my ability to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment at the representative's request made at anytime after I sign this form.

I choose not to provide Health Care Instructions, please go to the next page. _____ (Initial here)

LIVING WILL or HEALTH CARE INSTRUCTIONS

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a statement of my wishes.

I, _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems.

By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

Specific Instructions

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

	Provide	Withhold
Cardiopulmonary Resuscitation		_____
Artificial Respiration (including a respirator)		_____
Artificial means of providing nutrition and hydration		_____
_____		_____
_____		_____

Other specific requests: _____
_____
_____
_____
_____
_____
_____
_____
_____

I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

DOCUMENT OF ANATOMICAL GIFT

I make no anatomical gift at this time. _____ (Initial here)

I hereby make this anatomical gift, if medically acceptable, to take effect upon my death _____ (Initial here)

I give: (check one) ____ (1) any needed organs or parts
____ (2) only the following organs or parts:

_____
_____

to be donated for: (check one)
___ (1) any of the purposes stated in subsection (a) of section 19a-279f of the general statutes
___ (2) these limited purposes _____.

DESIGNATION OF A CONSERVATOR OF THE PERSON

I choose not to designate a person to be appointed as my conservator. _____ (Initial here)

If a conservator of my person should need to be appointed, I designate _____, be appointed my conservator.
If this person is unwilling or unable to serve as my conservator of my person, I designate _____ be appointed my conservator.
No bond shall be required of either of them in any jurisdiction.

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

x_____L.S. Date _____, 20____

WITNESSES' STATEMENTS

This document was signed in our presence by _____ the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

x_____	x_____
(Witness)	(Witness)
x_____	x_____
(Number and Street)	(Number and Street)
x_____	x_____
(City, State and Zip Code)	(City, State and Zip Code)

OPTIONAL FORM

WITNESSES' AFFIDAVITS

STATE OF CONNECTICUT)
)
) :ss._____
) (Town)
COUNTY OF _____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointment of a health care representative, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20____.

x_____ x_____
(Witness) (Witness)
x_____ x_____
(Number and Street) (Number and Street)
x_____ x_____
(City, State and Zip Code) (City, State and Zip Code)

Subscribed and sworn to before me by _____and _____, the signing witnesses to the foregoing affidavit this _____ day of _____, 20____.

_____

Commissioner of the Superior Court
Notary Public
My Commission expires: _____

(Print or type name of all persons signing under all signatures)

APPOINTMENT OF HEALTH CARE REPRESENTATIVE FORM

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I understand that, as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction and will turn to someone who knows my values and health care wishes. By signing this appointment of health care representative, I appoint a health care representative with legal authority to make health care decisions on my behalf in such case or at such time.

I appoint _____ to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment **my health care representative is authorized to (1) accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, such as psychosurgery or shock therapy as defined in Conn. Gen. Stat. § 17a-540, and (2) make the decision to provide, withhold or withdraw life support systems**.

I direct my health care representative to make decisions on my behalf in accordance with my wishes as stated in a living will, or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

If _____ is unwilling or unable to serve as my health care representative, I appoint _____ to be my alternative health care representative.

This request is made, after careful reflection, while I am of sound mind.

_____ / _____ / _____ (Date) X_____

WITNESSES' STATEMENTS

This document was signed in our presence by _____ the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

OPTIONAL FORM

WITNESSES' AFFIDAVITS

STATE OF CONNECTICUT)
)
) :ss._____
) (Town)
COUNTY OF _____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of this appointment of a health care representative by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20____.

x_____ x_____
(Witness) (Witness)
x_____ x_____
(Number and Street) (Number and Street)
x_____ x_____
(City, State and Zip Code) (City, State and Zip Code)

Subscribed and sworn to before me by _____and _____, the signing witnesses to the foregoing affidavit this _____ day of _____, 20____.

_____

Commissioner of the Superior Court
Notary Public
My Commission expires: _____

(Print or type name of all persons signing under all signatures)

LIVING WILL OR HEALTH CARE INSTRUCTIONS FORM

LIVING WILL or HEALTH CARE INSTRUCTIONS

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a statement of my wishes.

I, _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems.

By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

Specific Instructions

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

	Provide	Withhold
Cardiopulmonary Resuscitation		_____
Artificial Respiration (including a respirator)		_____
Artificial means of providing nutrition and hydration		_____
_____		_____
_____		_____

Other specific requests: _____
_____
_____
_____
_____
_____
_____
_____
_____

I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

This request is made, after careful reflection, while I am of sound mind.

_____ / _____ / _____ (Date) X_____

WITNESSES' STATEMENTS

This document was signed in our presence by _____ the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

x_____	x_____
(Witness)	(Witness)
x_____	x_____
(Number and Street)	(Number and Street)
x_____	x_____
(City, State and Zip Code)	(City, State and Zip Code)

OPTIONAL FORM

WITNESSES' AFFIDAVITS

STATE OF CONNECTICUT)
)
) :ss._____
) (Town)
COUNTY OF _____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of this living will or health care instructions by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20____.

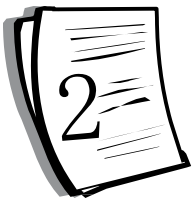
x_____ x_____
(Witness) (Witness)
x_____ x_____
(Number and Street) (Number and Street)
x_____ x_____
(City, State and Zip Code) (City, State and Zip Code)

Subscribed and sworn to before me by _____and _____, the signing witnesses to the foregoing affidavit this _____ day of _____, 20____.

_____

Commissioner of the Superior Court
Notary Public
My Commission expires: _____

(Print or type name of all persons signing under all signatures)



Medical Power Of Attorney

Designation of Health Care Agent:

I,_____(insert your name)

appoint: Name: _____

Address: _____

_____ Phone: _____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

Limitations On The Decision Making Authority Of My Agent Are As Follows:

_____

_____

_____

Medical Power Of Attorney

Designation of an Alternate Agent:
(You are not required to designate an alternate agent but you may do so.
An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s), to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternate Agent

Name: _____

Address: _____

_____ Phone: _____

Second Alternate Agent

Name: _____

Address: _____

_____ Phone: _____

The original of the document is kept at _____

_____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

Name: _____

Address: _____

Medical Power Of Attorney

Duration
I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney.

If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(If Applicable) This power of attorney ends on the following date:

Prior Designations Revoked
I revoke any prior medical power of attorney.

Acknowledgement of Disclosure Statement
I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information contained in this disclosure statement.

(You Must Date and Sign This Power of Attorney)

I sign my name to this medical power of attorney on the day of _____
(Month, year)

at _____
(City and State)

_____
(Print Name)

_____
(Signature)

Medical Power Of Attorney

Statement of First Witness

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death.

I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's death.

Furthermore, if I am an employee of a health care facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Signature: _____

Print Name: _____ Date: _____

Address: _____

Signature of Second Witness

Signature: _____

Print Name: _____ Date: _____

Address: _____