STATE OF CONNECTICUT

ADVANCE DIRECTIVES OF _____

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

1. My Living Will or Health Care Instructions
2. My Appointment of A Health Care Agent
3. My Appointment of An Attorney-in-Fact For Health Care Decisions
4. The Designation of My Conservator Of The Person For My Future Incapacity
5. My Document of Anatomical Gift

As my physician, you may rely on any information provided by my health care agent and decisions made by my attorney-in-fact for health care decisions or conservator of my person, if I am unable to make a decision for myself.

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 testament 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.

APPOINTMENT OF HEALTH CARE AGENT AND ATTORNEY-IN-FACT FOR HEALTH CARE DECISIONS

I appoint _____ to be my health care agent and my attorney-in-fact for health care decisions. 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, _____ is authorized;

As My Health Care Agent to:

1. Convey to my physician my wishes concerning the withholding or removal of life support systems;

2. Take whatever actions are necessary to ensure that any wishes are given effect;

As My Attorney-In-Fact to:

1. Act in my name, place and stead in any way which I myself could do, if I were personally present, with respect to health care decisions as defined in the Connecticut Statutory Short Form Power of Attorney Act to the extent that I am permitted by law to act through an agent;

2. Consent, refuse or withdraw consent to any medical treatment other than that designed solely for the purpose of maintaining physical comfort, withdrawal of life support systems, or withdrawal of nutrition or hydration.

If _____ is unwilling or unable to serve as my health care agent and my attorney-in-fact for health care decisions, I appoint _____ to be my alternative health care agent and my attorney-in-fact for health care decisions.

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

If a conservator of my person should need to be appointed, I designate _____, to be appointed my conservator. If _____ is unwilling or unable to serve as my conservator, I designate _____. 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.

Date _____, 20____
_____L.S.

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

Personally appeared _____, signer of the foregoing instrument, and acknowledged the same to be his/her free act and deed, before me, this _____ day of _____, 20___

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

WITNESSES' STATEMENT

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.

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

(NOTE: This Form is Optional)

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 appointments of a health care agent and an attorney-in-fact, 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____.

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

Personally appeared _____, signer of the foregoing instrument, and acknowledged the same to be his/her free act and deed, before me, 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)

_____
_____
_____

WITNESS FORM (NOTE: This Form is Optional)

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

We the undersigned, being duly sworn, depose and say:

That on the this date, the within named _____, signed the foregoing living will in our presence as witnesses; that we thereupon subscribed our names thereto as witnesses in (his/her) presence and at (his/her) request, and in the presence of each other; that at the time of the execution of said living will the said _____ appeared to be more than eighteen years of age and of sound mind and memory, and to the best of our judgment not under any improper restraint or influence or in any respect incompetent to make a living will; and that we make this affidavit at (his/her) request this _____ day of _____, 20____.

_____ _____
(Witness) (Witness)

_____ _____
(Number and Street) (Number and Street)

_____ _____
(City, State and Zip Code) (City, State and Zip Code)

Personally appeared _____, signer of the foregoing instrument, and acknowledged the same to be his/her free act and deed, before me, this _____ day of _____, 20____.

Subscribed and sworn to before me, on this _____ day of _____, 20____.

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

APPOINTMENT OF HEALTH CARE AGENT

I appoint _____(NAME) to be my health care agent. 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 agent is authorized to:(1) Convey to my physician my wishes concerning the withholding or removal of life support systems. (2) Take whatever actions are necessary to ensure that my wishes are given effect.

If this person is unwilling or unable to serve as my health care agent, I appoint

_____(NAME)
to be my alternative health care agent. This request is made, after careful reflection, while I am of sound mind.

Date _____, 20____

WITNESSES' STATEMENTS

This document was signed in our presence, by the above named _____ (NAME) who appeared to be eighteen years of age or older, or sound mind and able to understand the nature and consequences of health care decisions at the time the document was signed.

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

APPOINTMENT OF HEALTH CARE AGENT
WITNESS FORM (NOTE: This Form is Optional)

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

We, the undersigned, being duly sworn, depose and say:

That on the this date, the within named

_____, signed the foregoing appointment of health care agent in our presence as witnesses; that we thereupon subscribed our names thereto as witnesses in (his/her) presence and at (his/her) request, and in the presence of each other; that at the time of the execution of said appointment of health care agent the said _____ appeared to be more than eighteen years of age and of sound mind and memory, and to the best of our judgment not under any improper restraint or influence or in any respect incompetent to make an appointment of health care agent; and that we make this affidavit at (his/her) request this _____ day of _____, 20____.

_____ _____
(Witness) (Witness)

_____ _____
(Number and Street) (Number and Street)

_____ _____
(City, State and Zip Code) (City, State and Zip Code)

Subscribed and sworn to before me, on this _____ day of _____, 20___.

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

POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

Notice: The powers granted by this document are broad and sweeping. They are defined in Connecticut Statutory Short Form Power of Attorney Act, sections 1-42 to 1-56, inclusive, of the general statutes, which expressly permits the use of any other different form of power of attorney desired by the parties concerned. KNOW ALL MEN BY THESE PRESENTS, Which are intended to constitute a GENERAL POWER OF ATTORNEY pursuant to Connecticut Statutory Short Form Power of Attorney Act: That I: _____do hereby appoint: _____ my, attorney(s)-in-fact TO ACT: * *If more than one agent is designated and the principal wishes each agent alone to be able to exercise the power conferred, insert in this blank the word 'severally'. Failure to make any insertion or the insertion of the word 'jointly' shall require the agents to act jointly.

FIRST, In my name, place and stead in any way which I myself could do, if I were personally present, with respect to health care decisions as defined in the Connecticut Statutory Short Form Power of Attorney Act to the extent that I am permitted by law to act through an agent: **SECOND**, With full and unqualified authority to delegate any all of the foregoing powers to any person or persons whom my attorney(s)-in-fact shall select. **THIRD**, Hereby ratifying and confirming all that said attorney(s) or substitute(s) do or cause to be done. **FOURTH**, This Power of Attorney shall not be affected by my subsequent disability or incompetence of the principal herein named. **FIFTH**, I hereby agree that any third party receiving a copy or facsimile of this executed instrument may act in reliance thereon and that revocation or termination of this power of attorney shall be ineffective as to such third party unless and until actual notice or knowledge thereof shall have been received by such third party, and I, for myself and my heirs, assigns and legal representatives, hereby agree to indemnify and hold harmless any such third party from and against any and all claims that may arise against such third party by reason of reliance on such copy of this instrument. **SIXTH**, I hereby declare that, with respect to the powers conferred by this executed instrument, any and all such powers which may have been conferred in a previously executed instrument or instruments are hereby revoked.

In Witness Whereof, I have hereunto signed my name and affixed my seal this _____ day of _____, 20____.

Signed, sealed and delivered in presence of:

_____
Signature of Principal

_____ _____
(Witness) (Witness)

_____ _____
(Number and Street) (Number and Street)

_____ _____
(City, State and Zip Code) (City, State and Zip Code)

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

The foregoing POWER OF ATTORNEY was acknowledged before me this day _____ of _____, 20____, by _____
_____
(Principal)

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