



Advance Directive Form

This form allows you to communicate your health care wishes in the event you are unable to make decisions for yourself. Please complete the sections below to the best of your ability. This document is voluntary and can be updated or revoked at any time.

1. Patient Information

Full Name: _____

Student ID Number: _____

Date of Birth: _____

Phone Number: _____

2. Health Care Agent (Person to make decisions on your behalf)

Name: _____

Relationship: _____

Phone Number: _____

3. Treatment Preferences

In the event I am unable to make decisions for myself, I prefer the following care (check all that apply):

- ☐ I want all possible life-sustaining treatments.
- ☐ I do not want life-sustaining treatments if recovery is unlikely.
- ☐ I want comfort care only.

4. Signature

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Witness Signature: _____ Date: _____