Save Other Souls

DIRECTIVE

A HEALTH CARE DIRECTIVE FOR USE
DURING HEALTH EMERGENCY DUE TO COVID-19

After completing this form, sign and date it at the end. **The form should be signed by two witnesses.**

Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health-care agents you have named. Share it with your family members. In addition, you should sign and carry the attached wallet card.

There is currently an outbreak of respiratory disease called "Coronavirus Disease 2019" (COVID-19 or coronavirus). Governmental authorities have declared a state of emergency relating to this outbreak.

There are and/or may be shortages of equipment and other resources that are needed to treat people during this emergency, including in the area and hospitals in which I might need to receive care.

If there is an actual or impending shortage of life saving equipment, medication, and/or other medical bed space where I am being treated, regardless of whether I am being treated for COVID-19 or for some other condition, it is my wish and direction that any

health care providers and others involved in my care **DIRECT RESOURCES TO OTHERS RATHER THAN TO ME AS SET FORTH BELOW.**

I understand that this may prolong and/or worsen my medical condition and that it may lead to or hasten my death. I ask that my family, loved ones and caregivers honor my wishes which are intended to lessen any burden placed on them and on my care providers and minimize any feelings of guilt.

In the event of shortages, I am willing to receive compassionate palliative care instead of one or more of the following (check all that apply):

- ☐ Critical medical equipment (ventilator, ECMO, etc.)
- ☐ Medication (other than palliative)
- ☐ Critical care services in a hospital unit

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from such refusal.

I recognize that COVID-19 is caused by a novel coronavirus and that there is much that is unknown about who is most affected and how to treat it.

I am over 18 years of age, I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

This Directive supersedes any existing Advance Health Care Directive to the extent that they are inconsistent.

This Directive is effective only during the pendency of a national, state, or local-declared state of emergency related to COVID-19, and, in any event, not longer than 18 months from the date of my signing.

I execute this declaration, as my free and voluntary act, on this _____ day of _____, 20__, in the City of _____, County of _____, State of _____.

_____

(signature)

_____

(print name)

WITNESS DECLARATION

I declare under penalty of perjury under the laws of the state of _____ (1) that the individual who signed or acknowledged this directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this directive, (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community health care facility, an employee of the operator of a community health care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly, and (6) that I am an adult and am not related to the person signing this document by blood, marriage or adoption, and (7) that I am not entitled to and do not have a claim on any portion of the person's estate and am not otherwise restricted by law from being a witness.

Signed on this ____ day of _____, 20__.

_____

(name and address of first witness)

Signed on this ____ day of _____, 20__.

_____

(name and address of second witness)

NOTARIZATION*

On this the _____ day of _____, 20__, before me, the undersigned, a notary public in and for said County and State, personally appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

_____

(Signature of Notary)

* Notarization is not required by all jurisdictions. For state-by-state requirements, please check resources in your state which may be found through the American Bar Association's website, https://www.americanbar.org/content/dam/aba/administrative/law_aging/2018-lnks-to-st-spcifc-advnc-drctv-frms.pdf, or through your healthcare provider or lawyer.