ADVANCE HEALTHCARE DIRECTIVE

I, _____, born on _____, a ( ) male / ( ) female, a ( ) single / ( ) married person, and currently residing in (name of city) _____, Wyoming, intend to create an Advance Healthcare Directive pursuant to the Wyoming Health Care Decisions Act, WYOMING STATUTES §§ 35-22-401, et seq.

PART I: POWER OF ATTORNEY FOR HEALTHCARE

Designation of Agent: I designate the following individual as my Agent to make healthcare decisions for me:

Name of Agent: _____

Address: _____

City, State Zip Code: _____

Home Phone: _____

Work Phone: _____

Cellular Phone: _____

Relationship to Me: _____
(e.g., my spouse, brother, sister, son, daughter, friend, etc.)

Optional First Alternate Agent: If I revoke my Agent's authority, or if my Agent is not willing, able or reasonably available to make a healthcare decision for me, I designate as my First Alternate Agent:

Name of First Alternate: _____

Address: _____

City, State Zip Code: _____

Home Phone: _____

Work Phone: _____

Cellular Phone: _____

Relationship to Me: _____
(e.g., my spouse, brother, sister, son, daughter, friend, etc.)

The term "reasonably available" means able to be contacted with a level of diligence appropriate to the seriousness and urgency of my healthcare needs and willing and able to act in a timely manner considering the urgency of my healthcare needs.

_____

Optional Second Alternate Agent: If I revoke the authority of my Agent or First Alternate Agent, or if my Agent or First Alternate Agent is not willing, able or reasonably available to make a healthcare decision for me, I designate as my Second Alternate Agent:

Name of Second Alternate: _____

Address: _____

City, State Zip Code: _____

Home Phone: _____

Work Phone: _____

Cellular Phone: _____

Relationship to Me: _____
(e.g., my spouse, brother, sister, son, daughter, friend, etc.

Authority of Agent: My Agent is authorized to make all healthcare decisions for me according to the terms of this document and the moral teachings of the Catholic Church. For the purpose of this document, "healthcare" means any care, treatment, service or procedure to maintain, diagnose or otherwise affect my physical or mental condition.

When Agent's Authority Becomes Effective: My Agent's authority to make healthcare decisions becomes effective (*please initial one*):

____ When my primary healthcare provider determines that I lack capacity to make my own healthcare decisions.

____ Immediately.

For the purposes of this document, "capacity" means my ability to understand the significant benefits, risks and alternatives to proposed healthcare and to make and communicate a healthcare decision.

Agent's Obligation: My Agent shall make healthcare decisions for me in accordance with the terms of this document and the moral teachings of the Catholic Church. My Agent is to remember that as a member of the Catholic Church, I believe in a God who is merciful and in Jesus Christ who is the Savior of the World. As the Giver of Life, God has sent us His only-begotten Son as Redeemer so that in union with Him we might have eternal life. Through His death and resurrection, Jesus has conquered sin so that death has lost its sting (1 Corinthians 15: 55). My Agent is to follow the moral teachings of the Catholic Church and to see I receive all the obligatory care that my faith teaches we have a duty to accept. To the extent my wishes regarding my healthcare decisions are unknown, my Agent shall make healthcare decisions for me in accordance to what my Agent determines to be in my best interest. In determining my best interest, my Agent shall consider the moral teachings of the Catholic Church, my Catholic faith and my personal values to the extent all are known to my Agent.

_____

Nomination of Guardian: If a guardian of my person needs to be appointed for me by a court (*please initial one*):

____ I nominate my Agent(s) whom I named in this form to serve as guardian.

____ I nominate the following individual(s) to serve in the order designated, if there is more than one:

_____

_____

_____

____ I do not nominate a guardian in this document.

PART II: INSTRUCTIONS FOR HEALTHCARE

Most of what I state here is general in nature since I cannot anticipate all the possible circumstance of a future illness. I direct that those caring for me avoid doing anything that is contrary to the moral teachings of the Catholic Church. If I fall terminally ill, I ask that I be told of this so that I might prepare myself for death, and I ask that efforts be made that I be attended by a Catholic priest and receive the Sacraments of Reconciliation and Anointing of the Sick as well as Viaticum.

Those making decisions on my behalf should be guided by the moral teachings of the Catholic Church contained in, but not limited to, the following documents: *Declaration on Euthanasia*, Congregation for the Doctrine of the Faith, Rome, 1980; *Ethical and Religious Directives for Catholic Health Care Services*, National Conference of Catholic Bishops, November 1994; *Nutrition and Hydration: Moral and Pastoral Reflections*, Committee for Pro-Life Activities, National Conference of Catholic Bishops, March 1995; *Charter for Health Care Workers*, Pontifical Council for Pastoral Assistance to Health Care Workers, 1995; *Address to the 18th International Congress on the Transplantation Society*, Pope John Paul II, August 29, 2000; *Care for Patients in a "Permanent" Vegetative State*, Pope John Paul II, March 2004; *Palliative Care for the Dying*, Pope John Paul II, November 2004.

I want those making decisions on my behalf to avoid doing anything that intends and directly causes my death by deed or omission. Medical treatments may be forgone or discontinued if they do not offer a reasonable hope of benefit to me or if they entail excessive burdens, or impose excessive expense on me, my family or the community. There should be a presumption in favor of providing me with nutrition and hydration, even artificially, assuming of course that they are of benefit to me and not burdensome. In accord with the teachings of my Church, I have no moral objections to the use of medication or procedures necessary for my comfort even if they may indirectly and unintentionally shorten my life.

_____

End-of-Life Decisions: Death need not be resisted by any and every means, and my Agent has the right to refuse medical treatment that is excessively burdensome to me and would only prolong my death and delay my being taken to God. My Agent should see that I receive medication to relieve pain even if it is foreseen that its use may have the unintended result of shortening my life. If, in the medical judgment of my attending physician, who has personally examined me, death is imminent, even in spite of the means which may be used to conserve my life, and if I have received the Sacraments of the Church, I direct there be forgone or discontinued treatment that will only maintain a precarious and burdensome prolongation of my life, unless those responsible for my care judge that there are special and significant reasons why I should continue to receive such care.

Nutrition and Hydration: Nutrition and hydration may be discontinued when death is imminent (a matter of hours or a few days), provided their administration is no longer beneficial to me, they have become burdensome and discontinuing them is not intended or directed to cause my death; otherwise, I am to receive nutrition and hydration, even by artificial means.

Relief from Pain: Pain medicine and sedatives may be used even if they hasten my death, provided they are not intended or directed to cause my death. Efforts are to be made to keep me comfortable, clean and warm as I am dying.

Other Wishes: Believing none of the following directives conflicts with the teachings of my Catholic Faith, I hereby add the following special provisions and/or limitations to my future healthcare (*please initial any choices you desire*):

____ I would like reasonable steps to be taken to allow me to see my family, my close friends and my parish priest.

____ If at all possible, I would like to die at home, or at least in a home like atmosphere.

____ I have no objection to an autopsy being performed after my death, if my physicians and Agent judge it would be useful.

____ Other wishes: _____

_____

_____

PART III: DONATION OF ORGANS AT DEATH

Upon my death (*please initial one*):

____ I do not wish to donate my body or any organ.

____ I wish to donate my body.

_____

____ I wish to give any needed organs, tissues or parts.

____ I wish to give only the following organs, tissues or parts:

_____

_____

Donated tissues or organs are not to be removed until it has been medically determined that I have died. In order to prevent any conflict of interest, the physician who determines my death should not be a member of the transplant team. While either cardio-respiratory signs or neurological criteria may be used to determine my death, if neurological criteria are used, the complete and irreversible cessation of all brain activity (in the cerebrum, cerebellum and brain stem) must be clearly determined according to commonly held scientific means.

My gift is to be used for the following purposes (*please initial the choices you desire*):

____ Any purpose authorized by law and not contrary to Catholic moral teachings.

____ Transplantation.

____ Therapy.

____ Research.

____ Medical Education.

My body or any remaining parts or organs not used are to be treated with respect and charity, because of my faith and hope in the Resurrection of the Dead. Proper Christian burial of my body or cremains, and reverent disposition of other remains should be provided.

PART IV: PHYSICIANS

(*Please initial your choice(s).*)

____ I designate the following as my primary physician:

Physician's Name: _____

Address: _____

City, State Zip Code: _____

Phone: _____

_____

____ If the physician designated above is not willing, able or reasonably available to act as my primary physician, I designate the following as my primary physician:

Physician's Name: _____

Address: _____

City, State Zip Code: _____

Phone: _____

____ I do not choose to designate a primary physician in this document.

PART V: MISCELLANEOUS

This Advance Healthcare Directive is intended to be valid in any jurisdiction in which it is presented.

I retain the right to revoke or amend this Advance Healthcare Directive, and to make substitutions of my Agent, my Guardian Nominee and Physician.

I hereby revoke prior Living Wills and Powers of Attorney for Healthcare documents signed by me, and any agency relationships created under such documents (but not powers and agency relationships created under powers of attorney for financial matters).

A photocopy of this Advance Healthcare Directive signed by me shall have the same effect as the original document signed by me. Both the original and the photocopy shall be legally binding and shall constitute an original of one and the same document.

INSTRUCTIONS FOR EXECUTION

After completing this Advance Healthcare Directive, and in the presence of either two witnesses or a notary public, mark your initials near the bottom right-hand corner of each page, and in the space below print your full name, and then sign and date the document.

Be sure to give copies of this form to your physician(s), any other healthcare providers, any healthcare institutions from which you are receiving care, your Agent(s) and your Nominated Guardian(s).

_____ _____

Print Name Signature

_____

Date

_____

WITNESSES

I declare under penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is personally known to me to be the principal who 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, that I am not the person appointed to make health care decisions for the principal as the principal's attorney-in-fact, and that I am not a treating health care provider, an employee of a treating health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility, nor an employee of an operator of a residential care facility.

_____	_____
Witness 1 Print Name	Witness 1 Signature
_____	_____
Witness 1 Address	Date
_____	_____
Witness 2 Print Name	Witness 2 Signature
_____	_____
Witness 2 Address	Date

Or, In lieu of witnesses:

ACKNOWLEDGMENT

STATE OF WYOMING)
)SS
COUNTY OF _____)

This Advance Healthcare Directives was acknowledged before me, a notary public, by _____ on _____.

Witness by my hand and official seal.

_____
Notary Public Signature

My commission expires: _____

Reviewed November 6, 2019

_____