UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH

ADVANCE DIRECTIVES

DOCUMENTS TO ASSURE FUTURE HEALTH CARE CHOICES

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UNIVERSITY *of* MARYLAND
UPPER CHESAPEAKE HEALTH

PLEASE NOTE: Maryland Law Affecting Advance Directives

A patient currently under the care of a health care facility may not appoint an owner, operator, or employee/team member of that health care facility nor the spouse, parent, child or sibling of an owner, operator, or employee/team member, as his or her health care agent.

If the patient has appointed a health care agent prior to coming under the care of or prior to the time he or she contracted to receive care from a health care facility, the above persons may serve as that patient's health care agent.

A health care facility employee/team member, spouse, parent, child or sibling of a team member may qualify as a surrogate decision-maker and the new law does not change that process.

A surrogate decision-maker is someone who may be needed if the patient has not appointed a health care agent and the patient is unable to make his or her own health care decisions. The law has a list of surrogate decision-makers. Health care providers will go through the listed individuals, if they exist, in the following order until they find the proper surrogate: (1) a court appointed guardian; (2) patient's spouse; (3) patient's adult child; (4) patient's parents; (5) patient's adult brother or sister; (6) patient's friend or relative.

Should you have questions about the above information or any other aspect of Advance Directives, please contact the Guest Services department Monday thru Friday from 8:30am to 5pm. Should a question arise outside these hours, please contact the Administrative Coordinator by calling the hospital switchboard (see numbers below).

TTY users, please call through Maryland Relay.

University of Maryland Harford Memorial Hospital

Guest Services..443-843-5618
Switchboard...443-843-5000

University of Maryland Upper Chesapeake Medical Center
Guest Services..443-643-2400
Switchboard...443-643-1000

INTRODUCTION TO YOUR MARYLAND ADVANCE DIRECTIVE

This packet contains two legal documents: The Maryland Advance Directive that protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself, and the Maryland "After My Death" form, a document that allows you to record your decisions regarding organ donation and the final disposition of your remains.

The Maryland Advance Directive is divided into three parts. You may fill out Part I, Part II, or both, depending on your advance planning needs. **You must complete Part III.**

Part I, Selection of **Health Care Agent,** lets you name someone (an agent) to make decisions about your health care. This part becomes effective either immediately, or when your doctor determines that you can no longer make or communicate your health care decisions, depending on how you fill out the form.

Part II includes your **Treatment Preferences.** This is your state's living will. It lets you state your wishes about health care in the event that you can no longer speak for yourself. Part II has specific choices laid out for you in the event you have a terminal condition, are in a persistent vegetative state (permanent unconsciousness), or develop an end-stage condition. Alternatively, you can provide your own instructions. In addition, the form allows you to choose whether your agent will have flexibility in implementing your decisions or be required to carry out your instructions exactly as you set them out.

Part II becomes effective when your doctor determines that you can no longer make or communicate your health care decisions.

Part III contains the **signature and witnessing provisions** so that your document will be effective.

Following the Maryland Advance Directive is a form, called "After My Death," which allows you to record your organ donation and final remains disposition preferences.

Other important information:

The Maryland Advance Directive form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a directive tailored to your needs. The Maryland Department of Mental Health and Hygiene provides an advance directive focused on mental health issues on its website at http://www.dhmh.state.md.us/mha/forms.html

If you want information about Do Not Resuscitate (DNR) Orders, please visit http://marylandmolst.org or contact the Maryland Institute for Emergency Medical Services Systems directly at 410-706-4367. A Medical Orders for Life-Sustaining Treatment (MOLST) form contains medical orders regarding cardiopulmonary resuscitation (CPR) and other medical orders regarding life-sustaining treatments. A physician or nurse practitioner may use a MOLST form to instruct emergency medical personnel (911 responders) to provide comfort care instead of resuscitation. The MOLST form can be found on the Internet at: http://marylandmolst.org. From that page, click on "MOLST Form."

Part I of the Advance Directive: Selection of Health Care Agent

You can name anyone you want (except, in general, someone who works for a health care facility where you are receiving care) to be your health care agent. To name a health care agent, use Part I of the advance directive form. (Some people refer to this kind of advance directive as a "durable power of attorney for health care.") Your agent will speak for you and make decisions based on what you would want done or your best interests. You decide how much power your agent will have to make health care decisions. You can also decide when you want your agent to have this power right away, or only after a doctor says that you are not able to decide for yourself.

You can pick a family member as a health care agent, but you don't have to. Remember, your agent will have the power to make important treatment decisions, even if other people close to you might urge a different decision. Choose the person best qualified to be your health care agent. Also, consider picking one or two back-up agents, in case your first choice isn't available when needed. Be sure to inform your chosen person and make sure that he or she understands what's most important to you. When the time comes for decisions, your health care agent should follow your written directions.

Maryland State government has a helpful booklet that you can give to your health care agent. It is called "Making Medical Decisions for Someone Else: A Maryland Handbook." You or your agent can get a copy on the Internet by visiting the Attorney General's home page at: http://www.oag.state.md.us, then clicking on "Guidance for Health Care Proxies." You can also request a copy by calling 410-576-7000.

The form included with this pamphlet does not give anyone power to handle your money. Talk to your lawyer about planning for financial issues in case of incapacity.

Part II of the Advance Directive:
Treatment Preferences
("Living Will")

You have the right to use an advance directive to say what you want about future life-sustaining treatment issues. You can do this in Part II of the form. If you name a health care agent in addition to making decisions about treatment in an advance directive, it's important that you say (in Part II, paragraph G) whether you want your agent to be strictly bound by whatever treatment decisions you make.

Part II is a living will. It lets you decide about life-sustaining procedures in three situations: when death from a terminal condition is imminent despite the application of life-sustaining procedures; a condition of permanent unconsciousness called a persistent vegetative state; and an end-stage condition, which is an advanced, progressive, and incurable condition resulting in complete physical dependency. One example of an end-stage condition could be advanced Alzheimer's disease.

FREQUENTLY ASKED QUESTIONS ABOUT ADVANCE DIRECTIVES IN MARYLAND

1. ***Must I use any particular form?***
No. An optional form is provided, but you may change it or use a different form altogether. Of course, no health care provider may deny you care simply because you decided not to fill out a form.

2. ***Who can be picked as a health care agent?***
Anyone who is 18 or older except, in general, an owner, operator, or employee of a health care facility where a patient is receiving care.

3. ***Who can witness an advance directive?***
Two witnesses are needed. Generally, any competent adult can be a witness, including your doctor or other health care provider (be aware that some facilities have a policy against their employees serving as witnesses). If you name a health care agent, that person cannot be a witness for your advance directive. Also, one of the two witnesses must be someone who (i) will not receive money or property from your estate and (ii) is not the one you have named to handle your estate after your death.

4. ***Do the forms have to be notarized?***
No, but if you travel frequently to another state, check with a knowledgeable lawyer to see if that state requires notarization.

5. ***Do any of these documents deal with financial matters?***
No. If you want to plan for how financial matters can be handled if you lose capacity, talk with your lawyer.

6. ***When using these forms to make a decision, how do I show the choices that I have made?***
Write your initials next to the statement that says what you want. Don't use checkmarks or X's. If you choose, you can also draw lines all the way through other statements that do not say what you want.

7. ***Should I fill out both Parts I and II of the advance directive form?***
It depends on what you want to do. If all you want to do is name a health care agent, just fill out Parts I and III, and talk to the person about how they should decide issues for you. If all you want to do is give treatment instructions, fill out Parts II and III. If you want to do both, fill out all three parts.

8. ***Are these forms valid in another state?***
It depends on the law of the other state. Most state laws recognize advance directives made somewhere else.

9. ***How can I get advance directive forms for another state?***
Contact Caring Connections (NHPCO) at 1-800-658-8898 or visit http://www.caringinfo.org.

10. ***To whom should I give copies of my advance directive?***
Give copies to your doctor, your health care agent and backup agent(s), hospital or nursing home if you will be staying there, and family members or friends who should know of your wishes. Consider carrying a card in your wallet saying you have an advance directive and who to contact.

11. ***Does the federal law on medical records privacy (HIPAA) require special language about my health care agent?***
Special language is not required, but it is prudent. Language about HIPAA has been incorporated into the form.

12. ***Can my health care agent or my family decide treatment issues differently from what I wrote?***
It depends on how much flexibility you want to give. Some people want to give family members or others flexibility in applying the living will. Other people want it followed very strictly. Say what you want in Part II, Paragraph G.

13. ***Is an advance directive the same as a "Patient's Plan of Care," "Instructions on Current Life-Sustaining Treatment Options" form, or Medical Orders for Life-Sustaining Treatment (MOLST) form?***
No. These are forms used in health care facilities to document discussions about current life-sustaining treatment issues. These forms are not meant for use as anyone's advance directive. Instead, they are medical records, to be done only when a doctor or other health care professional presents and discusses the issues. A MOLST form contains medical orders regarding life-sustaining treatments relating to a patient's medical condition.

14. *Can my doctor override my living will?*
Usually, no. However, a doctor is not required to provide a "medically ineffective" treatment even if a living will asks for it.

15. *If I have an advance directive, do I also need a MOLST form?*
Yes. The MOLST form contains medical orders that will help ensure that all health care providers are aware of your wishes. If you don't want emergency medical services personnel to try to resuscitate you in the event of cardiac or respiratory arrest, you must have a MOLST form containing a DNR order signed by your doctor or nurse practitioner or a valid EMS/DNR form.

16. *Does the DNR Order have to be in a particular form?*
Yes. Emergency medical services personnel have very little time to evaluate the situation and act appropriately. So, it is not practical to ask them to interpret documents that may vary in form and content. Instead, the standardized MOLST form has been developed. Have your doctor or health care facility visit the MOLST website at http://marylandmolst.org or contact the Maryland Institute for Emergency Medical Services System at 410-706-4367 to obtain information on the MOLST form.

17. *Can I fill out a form to become an organ donor?*
Yes. Use Part I of the "After My Death" form.

18. *What about donating my body for medical education or research?*
Part II of the "After My Death" form is a general statement of these wishes. The State Anatomy Board has a specific donation program, with a pre-registration form available. Call the Anatomy Board at 1-800-879-2728 for that form and additional information.

19. *If I appoint a health care agent and the health care agent and any back-up agent dies or otherwise becomes unavailable, a surrogate decision-maker may need to be consulted to make the same treatment decisions that my health care agent would have made. Is the surrogate decision-maker required to follow my instructions given in the advance directive?*
Yes. The surrogate decision-maker is required to make treatment decisions based on your known wishes. An advance directive that contains clear and unambiguous instructions regarding treatment options is the best evidence of your known wishes and therefore must be honored by the surrogate decision-maker.

Part II, paragraph G enables you to choose one of two options with regard to the degree of flexibility you wish to grant the person who will ultimately make treatment decisions for you, whether that person is a health care agent or a surrogate decision-maker. Under the first option, you would instruct the decision-maker that your stated preferences are meant to guide him or her but may be departed from if he or she believes that doing so would be in your best interests. The second option requires the decision-maker to follow your stated preferences strictly, even if he or she thinks some alternative would be better.

Revised January 2013

MARYLAND ADVANCE DIRECTIVE: PLANNING FOR FUTURE HEALTH CARE DECISIONS

By: ______________________ Date of Birth: ______________
(Print Name) (Month/Day/Year)

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. Make sure you talk to your health care agent (and any back-up agents) about this important role. Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that, too.

You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive.

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

PART I: SELECTION OF HEALTH CARE AGENT

A. Selection of Primary Agent

I select the following individual as my agent to make health care decisions for me:

Name: ______________________________

Address: ______________________________

Telephone Number(s): ______________________________
(home and cell)

B. Selection of Back-up Agents
(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or, for any reason, is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: ______________________________

Address: ______________________________

Telephone Numbers: ______________________________
(home and cell)

2. If my primary agent and my first back-up agent cannot be contacted in time or, for any reason, are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: ______________________________

Address: ______________________________

Telephone Numbers: ______________________________
(home and cell)

C. Powers and Rights of Health Care Agent

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;

2. Decide who my doctor and other health care providers should be; and

3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.

4. I also want my agent to:
- **a.** Ride with me in an ambulance if ever I need to be rushed to the hospital; and
- **b.** Be able to visit me if I am in a hospital or any other health care facility.

THIS ADVANCE DIRECTIVE DOES NOT MAKE MY AGENT RESPONSIBLE FOR ANY OF THE COSTS OF MY CARE.

This power is subject to the following conditions or limitations:
(Optional; form valid if left blank)

____

____

____

____

____

D. How my Agent is to Decide Specific Issues

I trust my agent's judgment. My agent should look first to see if there is anything in Part II of this advance directive that helps decide the issue. Then, my agent should think about the conversations we have had, my religious and other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that he or she believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

E. People My Agent Should Consult

(Optional; form valid if left blank)

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent's power to make decisions.

Name(s)	Telephone Number(s):
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

F. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my agent shall follow these specific instructions:

____

____

____

G. Access to my Health Information – Federal Privacy Law (HIPAA) Authorization

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.

2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

H. Effectiveness of this Part

(Read both of these statements carefully. Then, initial one only.)

My agent's power is in effect:

1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

______________ (Initial here)

>>OR<<

2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability permanently.

______________ (Initial here)

If the only thing you want to do is select a health care agent, skip Part II. Go to Part III to sign and have the advance directive witnessed. If you also want to write your treatment preferences, go to Part II. Also consider becoming an organ donor, using the separate form for that.

PART II: TREATMENT PREFERENCES
("LIVING WILL")

A. Statement of Goals and Values
(Optional; form valid if left blank)

I want to say something about my goals and values, and especially what's most important to me during the last part of my life:

____

____

____

____

B. Preference in Case of Terminal Condition
(If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that my death from a terminal condition is imminent, even if life-sustaining procedures are used:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

____
(Initial here)

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

____
(Initial here)

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

____
(Initial here)

C. Preference in Case of Persistent Vegetative State

(If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

________________ (Initial here)

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

________________ (Initial here)

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

________________ (Initial here)

D. Preference in Case of End-Stage Condition

(If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in an end-state condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

________________ (Initial here)

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

______ (Initial here)

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

______ (Initial here)

E. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

F. In Case of Pregnancy
(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

____

____

____

G. Effect of Stated Preferences
(Read both of these statements carefully. Then, initial one only.)

1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

______ (Initial here)

>>OR <<

2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

______ (Initial here)

PART III: SIGNATURE AND WITNESSES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

______________________________ ________________

(Signature of Declarant) (Date)

The Declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

______________________________ ________________

(Signature of Witness) (Date)

____

Telephone Number(s):

______________________________ ________________

(Signature of Witness) (Date)

____

Telephone Number(s):

(Note: Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant's death. Maryland law does not require this document to be notarized.)

AFTER MY DEATH

(This document is optional. Do only what reflects your wishes.)

By: ______________________ Date of Birth: ______________
(Print Name) (Month/Day/Year)

PART I: ORGAN DONATION

(Initial the ones that you want. Cross through any that you do not want.)

Upon my death I wish to donate:

Any needed organs, tissues, or eyes: ______________________

Only the following organs, tissues or eyes: ______________________

____

____

I authorize the use of my organs, tissues, or eyes:

For transplantation ______________ (Initial here)

For therapy ______________ (Initial here)

For research ______________ (Initial here)

For medical education ______________ (Initial here)

For any purpose authorized by law ______________ (Initial here)

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead. This document is not intended to change anything about my health care while I am still alive. After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

PART II: DONATION OF BODY

The State Anatomy Board, a unit of the Department of Health and Mental Hygiene administers a statewide Body Donation Program. Anatomical Donation allows an individual to dedicate the use of his or her body upon death to advance medical education, clinical and allied-health training and research study to Maryland's medical study institutions. The Anatomy Board requires individuals to pre-register prior to death as anatomical donors to the state Body Donation Program. There are no medical restrictions or qualifications to becoming a "Body Donor." At death, the Board will assume the custody and control of the body for study use. It is truly a legacy left behind for others to have healthier lives.
For donation information and forms you can contact the Board toll-free at
1-800-879-2728

After any organ donation indicated in Part I, I wish for my body to be donated for use in a medical study program.

____
(Initial here)

PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS

I want the following person to make decisions about the disposition of my body and my funeral arrangements: (Either initial the first or fill in the second.)

The health care agent who I named in my advance directive.

____
(Initial here)

>>**OR**<<

This person:

Name: ____

Address: ____

Telephone Number(s): ________________________________
(home and cell)

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

____

____

PART IV: SIGNATURE AND WITNESSES

By signing below, I indicate that I am emotionally and mentally competent to make this donation and that I understand the purpose and effect of this document.

______________________________ _______________

(Signature of Donor) (Date)

The Donor signed or acknowledged signing the foregoing document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.

______________________________ _______________

(Signature of Witness) (Date)

Telephone Number(s): ______________________________

______________________________ _______________

(Signature of Witness) (Date)

Telephone Number(s): ______________________________

If you have other questions, please talk to your doctor or your lawyer. Or, if you have a question about the forms that is not answered in the pamphlet, you can call University of Maryland Upper Chesapeake Health Guest Services department Monday - Friday from 8:30am-5:00pm. Should a question arise outside of these hours, please contact the Administration Coordinator by calling the switchboard.

University of Maryland Harford Memorial Hospital
- Guest Services 443-843-5618
- Switchboard 443-843-5000

University of Maryland Upper Chesapeake Medical Center
- Guest Services 443-643-2400
- Switchboard 443-643-1000

For more information about Advance Directives call the Health Policy Division of the Attorney General's Office at 410-767-6918 or email them at adforms@oag.state.md.us

Did You Remember To…

- [ ] Fill out Part I if you want to name a health care agent?
- [ ] Name one or two back-up agents in case your first choice as health care agent is not available when needed?
- [ ] Talk to your agents and back-up agent about your values and priorities, and decide whether that's enough guidance or whether you also want to make specific health care decisions in the advance directive?
- [ ] Fill out Part II, choosing carefully among alternatives, if you want to make specific decisions?
- [ ] Sign and date the advance directive in Part III, in front of two witnesses who also need to sign?
- [ ] Look over the "After My Death" form to see if you want to fill out any part of it?
- [ ] Make sure your health care agent (if you named one), your family, and your doctor know about your advance care planning?
- [ ] Give a copy of your advance directive to your health care agent, family members, doctor, and hospital or nursing home if you are a patient there?

University of Maryland Harford Memorial Hospital
501 South Union Avenue • Havre de Grace, MD 21078
443-843-5000

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