Treatment Preference Declaration

Date: [Insert Date]

To Whom It May Concern,

I, [Your Name], hereby declare my preferences regarding medical treatment in the event that I am unable to communicate my wishes.

Preferred Treatments:

- [Preference 1: e.g., Life-sustaining treatment]
- [Preference 2: e.g., Palliative care only]
- [Preference 3: e.g., No resuscitation]

Additional Instructions:

[Any additional instructions or specific directives]

In case my primary physician is unavailable, I designate [Name of Alternative Physician] as my preferred healthcare provider to make decisions on my behalf.

Signature: _____

[Your Name]

[Your Contact Information]