Advanced Care Directive

Date: [Insert Date]

To Whom It May Concern,

I, [Your Full Name], born on [Your Date of Birth], residing at [Your Address], hereby express my wishes regarding my future medical care through this Advanced Care Directive.

Decision-Making Guidance

In the event that I am unable to communicate my wishes or make decisions regarding my health care, I would like the following guidance to be followed:

1. My preference is for [specific type of medical treatment or life-sustaining measures].
2. If my condition is deemed terminal, I request [specific requests regarding end-of-life care].
3. I designate [Name of Person] as my healthcare proxy to make decisions on my behalf.
4. Should I experience [specific medical conditions], I prefer the following interventions: [list preferences].
5. It is important that my values and beliefs be taken into account, particularly regarding [insert any personal values].

Signatures

Signed,

[Your Signature]

[Your Printed Name]

Witnessed By:

[Witness Signature]

[Witness Printed Name]

Contact Information

For further information or clarification, please contact me at [Your Phone Number] or [Your Email Address].

Thank you for respecting my wishes.

Sincerely,

[Your Full Name]