

How to use the Georgia Will to Live Form

SUGGESTIONS AND REQUIREMENTS

1. This document allows you to name a health care agent who will make health care decisions for you whenever you are unable to make them for yourself. It also allows you to give instructions concerning medical treatment decisions that the agent must follow.
2. Your doctor, nurse, or any other health care provider may not serve as your agent.
3. It is helpful to appoint successor agents to take over if your first agent is unable to serve. There is space on the form for you to name two successors to the agent.

Note: You may wish to name a guardian for yourself on page 1 in case a court decides that one should be appointed for you at some time. You may, but are not required to, nominate as your guardian the same person you named as your health care agent. Under Georgia law, even if a guardian is appointed for you, if you have named a health care agent, the health care agent rather than the guardian will have authority to make decisions concerning your health care.
4. Your agent's authority takes effect only when you no longer have the capacity to make health care decisions. It does not include the authority to authorize psychosurgery, sterilization, or involuntary mental health hospitalization or treatment.
5. You must sign and date this document in the presence of at least two witnesses who are at least 18 years of age and of sound mind. The witnesses cannot be your health care agent or successor health care agent, anyone who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death, or anyone who is directly involved in your health care. Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care). (If you are unable to sign and date the document yourself, you may direct someone to do it for you in your presence.) The two witnesses should provide their signatures and addresses below your signature in the space provided in the document.
6. A properly signed and witnessed declaration will remain in effect until you revoke (cancel) it. The revocation may be made in writing (signed and dated by you); orally (in the presence of a witness at least 18 years of age who, within 30 days, puts it in writing and signs and dates it); or in any other way in which you indicate your intention to revoke.

7. **Unless your document specifies otherwise, if, after having made this Advance Directive for Health Care, you get married, your marriage will revoke the designation of the person it names as your agent unless he or she is your spouse.** And if, after having made this declaration, your marriage is dissolved or annulled, your former spouse will automatically be removed as your agent to make health care decisions.
8. You should tell your doctor about this document. You should also ask your doctor to keep a copy of this document as a part of your medical health record. Give copies of the signed original to your health care agent, family members, and anyone else you think appropriate. Keep the original document in a safe place that will be easily accessible to others in case of any emergency and tell someone where it is.
9. This type of document has been authorized by the Georgia Advance Directive for Health Care Act, Ga. Code §§31-32-1 to -14.
10. You should periodically review your document to be sure it complies with your wishes. Before making any changes, be aware that it is possible that the statutes controlling this document have changed since this form was prepared. Contact the Will to Live Project by visiting www.nrlc.org (click on “Will to Live”) or an attorney to determine if this form can still be used.
11. If you have any questions regarding the information in this document or want assistance filling it out, please consult an attorney.

For additional copies of the Will to Live, please visit www.nrlc.org.

form prepared 2001
*clerical corrections made 05/11

**Georgia Advance Directive for Health Care
WILL TO LIVE FORM**

HEALTH CARE AGENT made this _____ day of _____, 20____.

I, (your name)_____

(your address)_____

(your phone number)_____

hereby appoint:

(Name of agent)_____

(address of agent)_____

(phone number(s) of agent)_____

as my attorney-in-fact (my agent) to act for me and in my name in any way I could act in person to make any and all decisions for me concerning my health care and to consent to health care in accordance with the following instructions. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others.

If any agent named by me shall die, become legally disabled, incapacitated, or incompetent, or resign, refuse to act, or be unavailable, I name the following (each to act successively in the order named) as successors to such agent:

1. _____

(first successor's name, address, and telephone number)

2. _____

(second successor's name address, and telephone number)

*(The following paragraph is **OPTIONAL**. If you do **not** want to nominate a guardian, **CROSS OFF** the blank lines and **initial** your cross-off.)*

If a guardian of my person is to be appointed, I nominate the following to serve as my guardian:

(nominated guardian's name, address, and phone number _____

GENERAL PRESUMPTION FOR LIFE

I direct my health care provider(s) and health care attorney in fact(s) to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

Food and water are not medical treatment, but basic necessities. I direct my health care provider(s) and health care attorney in fact to provide me with food and fluids, orally, intravenously, by tube, or by other means to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided, as long as the medication is not used in order to cause my death.

I direct that the following be provided:

- the administration of medication;
- cardiopulmonary resuscitation (CPR); and
- the performance of all other medical procedures, techniques, and technologies, including surgery,

—all to the full extent necessary to correct, reverse, or alleviate life-threatening or health impairing conditions or complications arising from those conditions.

I also direct that I be provided basic nursing care and procedures to provide comfort care.

I reject, however, any treatments that use an unborn or newborn child, or any tissue or organ of an unborn or newborn child, who has been subject to an induced abortion. This rejection does not apply to the use of tissues or organs obtained in the course of the removal of an ectopic pregnancy.

I also reject any treatments that use an organ or tissue of another person obtained in a manner that causes, contributes to, or hastens that person's death.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age or physical or mental disability or the "quality" of my life. I reject any action or omission that is intended to cause or hasten my death.

I direct my health care provider(s) and health care attorney in fact to follow the policy above, even if I am judged to be incompetent.

During the time I am incompetent, my attorney in fact, as named below, is authorized to make medical decisions on my behalf, consistent with the above policy, after consultation with my health care provider(s), utilizing the most current diagnoses and/or prognosis of my medical condition, in the following situations with the written special instructions.

WHEN MY DEATH IS IMMINENT

A. If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn: **(Be as specific as possible; SEE SUGGESTIONS.):**

(Cross off any remaining blank lines.)

WHEN I AM TERMINALLY ILL

B. Final Stage of Terminal Condition. If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:

(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

C. OTHER SPECIAL CONDITIONS:

(Be as specific as possible; SEE SUGGESTIONS.):

(Cross off any remaining blank lines.)

IF I AM PREGNANT

D. Special Instructions for Pregnancy. If I am pregnant, I direct my health care provider(s) and health care attorney in fact(s) to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even if I am legally determined to

be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

Signature of Declarant

This power of attorney shall be effective in the event I become disabled, incapacitated or incompetent.

[You must sign and date or acknowledge signing and dating this form in the presence of two witnesses.

Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

A witness:

--Cannot be a person who was selected to be your health care agent or back-up health care agent;

--Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or

--Cannot be a person who is directly involved in your health care.

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).]

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

Signed _____
(Signature of principal)

Date _____

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

Witnesses:

Addresses:

You may, but are not required to, request you agent and successor agents to provide specimen signatures below. If you include specimen signatures in this power of attorney, you must complete the certification opposite the signatures of the agents.

Specimen signatures of agent and
successor(s)

I certify that the signature of my agent and
successor(s) is correct.

(agent)

(your name)

(first successor agent)

(your name)

(second successor agent)

(your name)

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