My Advance Care Plan

Have the TALK – leave no doubt with your family about your healthcare wishes!

- ✓ Use the attached form to document your healthcare wishes.
- ✓ Remember that the most important part of making medical choices is to TALK about them!
- ✓ TALK about your Advance Care Plan with your family and your Healthcare Agents.
- ✓ TALK about it with your doctor.

If you have questions about making medical choices or completing your Advance Care Plan, call the Sentara Center for Healthcare Ethics at (757) 252-9550 for assistance.

Atención: si habla español, tiene a su disposición servicios lingüísticos gratuitos. Llame al 844-809-6648.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 844-809-6648 번으로 전화해 주십시오.

注意：如果您讲中文普通话，则将为您提供免费的语言辅助服务。请致电 844-809-6648。

ATTENTION: Language assistance services are available to you free of charge. Call 844-809-6648.

Sentara complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

THE U.S. LIVING WILL REGISTRY

This service is provided by Sentara FREE of charge to our community. You can store your Advance Care Plan on the Registry so it will be available to any health care provider in Virginia and North Carolina as well as any providers across the U.S. Once registered, you will receive an acknowledgment along with a wallet card and stickers for your ID cards that will alert medical professionals that you have an Advance Care Plan on file with the Registry and the 800 number so they can retrieve it.

If you want to have your document registered, you must complete the U.S. Living Will Registry Registration Agreement, giving the Registry permission to store your Advance Care Plan and provide it to any healthcare facility that requests a copy, and attach your Advance Care Plan.

What do I do with my ACP?

1. Make enough copies* and provide one each to:
    a. Your appointed Healthcare Agents
    b. Family members
    c. Doctor
    d. The US Living Will Registry through the Sentara Center for Healthcare Ethics***
2. Keep the original yourself in a safe and accessible place.
3. ***Mail a copy of your document to:

The Sentara Center for Healthcare Ethics
4705 Columbus Street, Suite 303
Virginia Beach VA 23462
or fax to our secure line at 757-995-7337

*Copies are the same as the original in North Carolina

U.S. Living Will Registry® Registration Agreement

SOURCE CODE: 36901001

Registrant's Identifying Information (Please print clearly)

Name: First _____ Middle _____ Last _____ Suffix ____

Social Security # XXX - XX -_____ **Date of Birth** Month ____ Day ____ Year _____ (4 digits)

Email address for Registrant or Emergency Contact: _____

* Annual update reminders will be sent via email (email addresses will not be shared or sold)

Street Address _____ Apt # _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone: (_____) _____ - _____ **Alternate Phone:** (_____) _____ - _____

Emergency Contact Name: _____ **Relationship:**_____

Address:_____

Primary Phone: (_____) _____ - _____ **Alternate Phone:** (_____) _____ - _____

I,_____ ("Registrant" or "I"), authorize U.S. Living Will Registry®, with offices at 808 South Ave. West, P.O. Box 2789 Westfield, NJ 07091-2789 ("Registry"), to electronically store a copy of my advance directive(s) provided to Registry with this registration form or subsequently, including but not limited to a living will, health care proxy, durable power of attorney for health care and/or financial matters, Medical or Physician Orders for Scope of Treatment (POST) organ donation wishes and emergency contact information ("Advance Directives"). I further authorize the Registry to make available a copy of the stored Advance Directive(s) to any health care provider or other person believed charged with giving effect to my Advance Directive(s) or assisting in same, who requests it in conjunction with my care, provided such a request is consistent with the Registry's policies and procedures, or as deemed advisable by the Registry in an emergency situation, or as required by law. The Advance Directive(s) that I am providing is my current, effective Advance Directive(s), and was signed and witnessed in accordance with the law of the state of my residence.

I hereby authorize Registry to make available a copy of my Advance Directive(s) to hospitals, physicians, or other health care providers involved with my care, or anyone who has access to the wallet identification ("ID") card provided to me by Registry. I understand this authorization is voluntary. I agree to notify Registry immediately if I decide to revoke or change my Advance Directive(s) stored with Registry and to provide Registry with a copy of any additional Advance Directive(s) that I sign. I understand that unless I terminate this authorization or inform Registry of revocation or changes to my Advance Directive(s), the Advance Directive(s) stored with Registry will be provided to health care providers in accord with Registry policies and practices.

I understand that Registry makes no representations about the validity of my Advance Directive(s) under federal or state law and that Registry bears no responsibility for the actions taken by health care providers in relation to my Advance Directive(s). I hereby waive any and all legal claims against Registry for the actions and omissions by any health care providers who receive a copy of my Advance Directive(s) from Registry and for any damages arising from the transmission or disclosure of the Advance Directive(s) I provide to Registry. Registry shall not be liable for the loss, destruction or unavailability of all or part of my Advance Directive(s).

I understand that I may revoke this authorization at any time by giving written notice of my revocation to Registry. This Agreement will remain in force until revoked by me or until terminated in accordance with the agreement between me and Registry or until registration is cancelled pursuant to the Registry's policies and procedures. When the Agreement is terminated, I understand that Registry will remove my Advance Directive(s) from its files.

I understand that anyone who gains access to my wallet ID card provided by Registry can use it to gain access to my Advance Directive(s) and personal information stored with Registry, and I will not hold the Registry liable for such authorized or unauthorized access.

I hereby agree to the terms set forth herein.

X_____ DATED:____/_____/_____

Signature of Registrant

Communicating my Healthcare Wishes

Name: _____ Social Security Number: XXX – XX - _____

Address: _____ City: _____ State & ZIP: _____

Phone: (_____) _____ - _____ Date of Birth: _____ - _____ - _____

Sentara Healthcare Advance Directive
USLWR Source Code 36901001

Section I: Healthcare Power of Attorney

If lack sufficient understanding or capacity to make or communicate decisions relating to my healthcare, as determined by my attending physician, I appoint the person(s) listed below to be my designated Healthcare Agent(s) to act for me with the full power and authority to make healthcare decisions for me to the same extent that I would be able to do for myself if I had capacity.

My primary healthcare agent, as designated below, shall serve alone. The secondary healthcare agent shall serve when the primary healthcare agent is not reasonably available or is unwilling or unable to serve in that capacity:

Primary Healthcare Agent:

Name: _____ Phone: (_____) _____-_____

Address: _____ Alt. Phone: (_____) _____-_____

_____

Secondary Healthcare Agent:

Name: _____ Phone: (_____) _____-_____

Address: _____ Alt. Phone: (_____) _____-_____

_____

_____ If I initial this line, my agent WILL have the authority to restrict visitors in a healthcare facility.
(Initials)

General Healthcare Instructions/Limitations:

_____
_____
_____
_____
_____

Section II: Organ Donation:

I authorize my agent to exercise any right I may have to:

_____ Donate any needed organs or parts; OR
(Initials)

_____ Donate my body for anatomical study if needed.

Section III: Advance Directive for a Natural Death

Name: _____ Social Security Number: XXX-XX-_____

(***Initial*** *beside any instructions you wish to include)*

If I lack sufficient understanding or capacity to make or communicate decisions relating to my healthcare, and:

_____ (Initials) I have an incurable or irreversible condition that will result in my death within a relatively short period of time.

_____ (Initials) I become unconscious and my healthcare providers determine that, to a high degree of medical certainty, I will never regain consciousness.

_____ (Initials) I suffer from advanced dementia or any other condition which results in the substantial loss of my cognitive ability and my healthcare providers determine that, to a high degree of medical certainty, this loss is not reversible.

Then:

_____ (Initials) I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I am aware that this declaration authorizes a physician to withhold or discontinue these life-prolonging measures. I will still receive treatment to relieve pain and make me comfortable. **OR**

_____ (Initials) I want all treatments to prolong my life as long as possible within the limits of generally accepted healthcare standards.

_____ (Initials) If medically appropriate, I wish to include the following treatment instructions:

_____

Section IV

By signing below, I indicate that I am of sound mind and understand this document, and I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

This the _____ day of _____, 20_____

_____ Date: _____

My signature (required)

I hereby state that the declarant/principal being of sound mind, signed this document in my presence. I am not related to the declarant/principal by blood or marriage, and I would not be entitled to any portion of the estate of the declarant/principal under any existing will or codicil, or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the declarant/principal's attending physician, nor a licensed healthcare provider who is an employee of the attending physician, an employee of the health care facility in which the declarant/principal is a patient, or an employee of a nursing home or adult care home where the declarant/principal resides. I further state that I do not have any claim against the declarant/principal or the estate of the declarant/principal.

Witness #1 Signature: _____ Date: _____

Witness #2 Signature: _____ Date: _____

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by _____ *(Print Declarant Name)*

_____ *(Print Witness #1 Name)*

_____ *(Print Witness #2 Name)*

DATE _____

(*Official Seal)*

Notary Signature: _____

Notary Name: _____, Notary Public

My commission expires: _____