**DRAFT**

**PLAIN LANGUAGE VERSION Sections 1, 5, 6**

**July 17, 2020**

**Oregon Advance Directive for Health Care**

This **Advance Directive form** allows you to:

* Share your goals and wishes for health care if you were not able to express them yourself.
* Name a person to make your health care decisions if you could not make them for yourself. This person is called your health care representative.

Be sure to discuss your Advance Directive and your wishes with your health care representative. This would allow them to make decisions that reflect your wishes.

**It is best to complete this entire form.**

* To appoint a health care representative, complete Sections 1, 2, 5, 6, and 7.

* To provide instructions, complete Sections 3 and 4.

If you do not appoint a health care representative, a decision maker will be assigned. This is explained in Oregon’s Advance Directive law.

**More about this form**:

* This new form will replace any older one you have filled out.
* For this form to be valid:
	+ You must sign it.
	+ You must have it witnessed by two adults or a Notary.
	+ Your health care representative must accept the role.

* You may cancel your Advance Directive at any time and in any manner that shows your desire to cancel it. This is the case as long as you are able to make medical decisions.  This is also the case if your Advance Directive includes directions about the withdrawal of life support or tube feeding.
1. **About Me**

Name: Date of birth:

Telephone numbers:(Home) \_\_ (Work) (Cell) \_\_\_

Address: \_\_\_\_\_

Email:

1. **My Heath Care Representative**

I choose this person as my health care representative. They would make health care decisions for me if I could not speak for myself.

 Name: Relationship: \_\_\_\_\_

Telephone numbers: (Home) \_\_ (Work) (Cell) \_\_\_

Address: \_\_\_\_\_

Email:

I choose the people below to be my alternate health care representatives. This is in the case that my first choice is not able to make health care decisions for me.

First alternate:

Name: Relationship:

 Telephone Numbers:(Home) (Work) (Cell)

 Address:

Email:

 Second alternate:

Name: Relationship:

 Telephone numbers:(Home) (Work) (Cell)

 Address:

 Email:

1. **My Signature**

Stop. Please only sign this in front of your witness.

 My signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Witness**

 When you sign, have your witness complete **either** A or B.

1. **Notary**:

State of

County of

Signed or attested before me on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2\_\_\_\_\_, by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public – State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Witness**:

The person filling out this form is known to me or has shown proof of identity. They have signed or acknowledged their signature on this form in my presence. This person does not appear to be under duress. This person appears to understand the purpose and effect of this form. Also, I am not this person’s main or alternate health care representative. And I am not this person’s health care provider.

Witness Name (print):

Signature: Date:

Witness name (print):

Signature: Date:

1. **Acceptance by My Health Care Representative**

I accept this role and agree to serve as health care representative.

Health care representative:

Printed name:

Signature or other verification of acceptance:

Date:

First alternate health care representative:

Printed name:

Signature or other verification of acceptance:

Date:

Second alternate health care representative:

Printed name:

Signature or other verification of acceptance:

Date: