

# ~ Alberta ~

## Personal Directive Christian Version

### NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care and other personal matters. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long-term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person or persons whom you want to make health care decisions for you if you are unable to participate in medical treatment decisions and make those decisions personally. That person serves as your proxy and is known as your agent for personal care, or simply agent. You can also give your agent the ability to make decisions for all of your personal (non-financial) matters – for example, you can give your agent the authority to make decisions regarding your accommodation, participation in educational and social activities, and other personal matters. You should take some time to discuss your thoughts and beliefs about medical treatment and other personal matters with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your agent. If your agent is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your agent broad powers to make health care decisions for you. If you initial Paragraph 1 “Revocation of Previous Directive,” then this document revokes any prior personal directive that you may have made. If you wish to change your personal directive, you may revoke this document at any time by making a subsequent personal directive that contradicts this directive; by making any document, including a subsequent personal directive, that expresses an intention to revoke this document or part of it; or by destroying all of the originals of this personal directive with the intention of revoking it. If you revoke, you should notify your agent for personal care, your health care providers and any other person to whom you have given a copy.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document with your personal papers where it can be easily accessed by your health care agent, close family, or friends, if needed.

# ALBERTA PERSONAL DIRECTIVE

Written in accordance with the *Personal Directives Act* – Province of Alberta

Document made this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.  
Month Year

## CREATION OF PERSONAL DIRECTIVE

I, \_\_\_\_\_, make this Personal Directive.  
Name of maker

This Personal Directive takes effect with respect to personal matters that relate to me when it is determined, in accordance with the *Personal Directives Act*, that I do not have capacity to make personal decisions with respect to those matters.

## INITIALS

I have placed my initials next to the provisions in this document that form part of my Personal Directive. My witness has also placed his/her initials next to the provisions initialed by me.

### 1. REVOCATION OF PREVIOUS DIRECTIVE

I revoke all previous personal directives made by me.

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

### 2. DESIGNATION OF AGENT

I designate the following as my Primary Agent(s):

#### Primary Agent(s)

\_\_\_\_\_  
Name(s) of Primary Agent(s)

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

If he/she or they are ever unable or unwilling to serve as my Primary Agent(s), I hereby designate:

#### First Alternate

\_\_\_\_\_  
Name(s) of First Alternate Agent(s)

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Address

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

to be my First Alternate Agent(s). If he/she or they are ever unable or unwilling to serve as my First Alternate Agent(s), I hereby designate:

**Second Alternate**

\_\_\_\_\_  
Name(s) of Second Alternate Agent(s) Phone

\_\_\_\_\_  
Address

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

to be my Second Alternate Agent(s).

If I have named more than one agent I direct that they consult with each other and agree upon decisions. If my Primary Agent, or both of my Primary Agents if I have named more than one, is unable or unwilling to serve in that capacity, then my First Alternate Agent(s) will make the decisions. If my First Alternate Agent, or both of my First Alternate Agents if I have named more than one, are unable or unwilling to serve, then my Second Alternate Agent(s) will make the decisions.

**OR**

I designate the Public Guardian as my agent.

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

**OR**

I do **NOT** wish to designate an agent, but provide the following information and instructions to be followed by a service provider who intends to provide personal services to me.

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

**3. AREAS OF AUTHORITY**

I give my Agent(s) designated in Section 2 above the authority to make personal decisions on my behalf for all the personal matters, of a non-financial nature, that relate to me.

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

**OR**

I give the following Agent(s) the authority to make personal decisions on my behalf for the personal matters, of a non-financial nature, that relate to me that are listed below. If I have not specified one or more Agent(s) for a personal matter listed below, then the Agent(s) listed in Section 2 shall have the authority to make decisions on my behalf for that personal matter.

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

**HEALTH CARE**

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

\_\_\_\_\_  
[Name(s) of agent(s)]

**ACCOMMODATION**

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

\_\_\_\_\_  
[Name(s) of agent(s)]

WITH WHOM I MAY LIVE AND ASSOCIATE

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

\_\_\_\_\_  
[Name(s) of agent(s)]

PARTICIPATION IN SOCIAL ACTIVITIES

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

\_\_\_\_\_  
[Name(s) of agent(s)]

PARTICIPATION IN EDUCATIONAL ACTIVITIES

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

\_\_\_\_\_  
[Name(s) of agent(s)]

PARTICIPATION IN EMPLOYMENT ACTIVITIES

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

\_\_\_\_\_  
[Name(s) of agent(s)]

LEGAL MATTERS

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

\_\_\_\_\_  
[Name(s) of agent(s)]

OTHER PERSONAL MATTERS AS FOLLOWS:

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

\_\_\_\_\_  
[Name(s) of agent(s)]

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

[Attach additional pages, if needed.]

**4. DESIGNATION OF AGENT FOR TEMPORARY CARE AND EDUCATION OF MINOR CHILD(REN) [OPTIONAL]**

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

I designate \_\_\_\_\_

[Name of agent]

as an agent who has the authority to take over the care and education of my minor child(ren) until one of the events described in section 7(1)(e) of the *Personal Directives Act* happens.

**5. SPECIFIC INSTRUCTIONS**

Initial by Maker [ \_\_\_\_\_ ]  
Initial by Witness [ \_\_\_\_\_ ]

I instruct my agent(s) to carry out the following specific instructions when making decisions about my personal matters.

1. I request that the attached Addendum (pages 8-10) be included as a valid part of this Personal Directive and that my Agent(s) consider my philosophy and beliefs which are set forth in the Addendum when making personal decisions on my behalf.
2. I request, but not as a requirement, that my Agent(s) consult my clergy regarding health care decisions.
3. My Agent(s) may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for persons with an intellectual disability, or a treatment facility. My Agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

4. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[Attach additional pages, if needed.]

Initial by Maker [ \_\_\_\_\_ ] If I have not designated an agent, or if my Agent(s) are unable or  
Initial by Witness [ \_\_\_\_\_ ] unwilling to make a personal decision or cannot be contacted after  
every reasonable effort has been made, I instruct a service provider who intends to provide services to me to  
follow the following instructions that are relevant to the decisions to be made:

1. I request that the attached Addendum (pages 8-10) be included as a valid part of this Personal Directive and that my service provider consider my philosophy and beliefs which are set forth in the Addendum when providing services to me.
2. I request, but not as a requirement, that my service provider consult my clergy before providing health care services to me.

3. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[Attach additional pages, if needed.]

## 6. OTHER INFORMATION

Initial by Maker [ \_\_\_\_\_ ] I provide the following information to help my Agent(s) understand  
Initial by Witness [ \_\_\_\_\_ ] my wishes, beliefs and values when making decisions about my  
personal matters:

1. Despite the creation of this personal directive, I expect to be fully informed about and allowed to participate in personal decisions made on my behalf for all personal matters relating to me, to the extent that I am able. In particular, I expect to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For this purpose “health care decision” means an informed decision to accept, maintain, discontinue, or refuse any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition.

2. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[Attach additional pages, if needed.]

## 7. WHO DETERMINES MY CAPACITY [OPTIONAL]

Initial by Maker [ \_\_\_\_\_ ] I designate \_\_\_\_\_,  
Initial by Witness [ \_\_\_\_\_ ] [Name of Individual(s)]  
to determine my capacity under Section 9 of the *Personal Directives Act*.

## 8. NOTIFICATION [OPTIONAL]

Initial by Maker [ \_\_\_\_\_ ] If a determination is made under the *Personal Directives* Act that I lack  
Initial by Witness [ \_\_\_\_\_ ] capacity to make personal decisions, I instruct the person making the  
determination to provide a copy of the declaration to me, the Agent(s) I have designated in this Personal  
Directive, if any, and the following people:

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[Attach additional pages, if needed.]

**The person creating this document and the witness must sign the document at the same time.**

## 9. SIGNATURES

Signed by me in the presence of my witness at \_\_\_\_\_  
(Location)

in the Province of Alberta, this \_\_\_\_\_ of \_\_\_\_\_,  
(Day) (Month) (Year)

\_\_\_\_\_  
(Signature of Maker)

\_\_\_\_\_  
(Signature of Witness in the presence of Maker)

\_\_\_\_\_  
(Printed Name of Witness)

\_\_\_\_\_  
(Address of Witness)

**NOTE:** The following persons may not witness the signing of a personal directive:

- A person designated in the directive as an agent
- The spouse or adult interdependent partner of a person designated in the directive as an agent
- The spouse or adult interdependent partner of the maker
- A person who signs the directive on behalf of the maker
- The spouse or adult interdependent partner of a person who signs the directive on behalf of the maker.

## 10. ACKNOWLEDGEMENT [OPTIONAL]

I (We) acknowledge that I (we) have received a copy of this personal directive.

\_\_\_\_\_  
(Name of Agent)

\_\_\_\_\_  
(Signature of Agent)

\_\_\_\_\_  
(Location where signed)

\_\_\_\_\_  
(Date of signing)

\_\_\_\_\_  
(Telephone Numbers of Agent)

\_\_\_\_\_  
(Address of Agent)

\_\_\_\_\_  
(E-mail Address of Agent)

\_\_\_\_\_  
(Name of Agent)

\_\_\_\_\_  
(Signature of Agent)

\_\_\_\_\_  
(Location where signed)

\_\_\_\_\_  
(Date of signing)

\_\_\_\_\_  
(Telephone Numbers of Agent)

\_\_\_\_\_  
(Address of Agent)

\_\_\_\_\_  
(E-mail Address of Agent)

\_\_\_\_\_  
(Name of Agent)

\_\_\_\_\_  
(Signature of Agent)

\_\_\_\_\_  
(Location where signed)

\_\_\_\_\_  
(Date of signing)

\_\_\_\_\_  
(Telephone Numbers of Agent)

\_\_\_\_\_  
(Address of Agent)

\_\_\_\_\_  
(E-mail Address of Agent)

# ADDENDUM TO THE ALBERTA PERSONAL DIRECTIVE

## MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief in the inherent value of human life and that life is a gift from God. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life, and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life exists at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

## HEALTH CARE DIRECTIVES

1. I direct my Agent to consent to the following health care:
  - a. Health care that is intended to relieve pain or to make me comfortable.
  - b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.
2. My Agent has no authority to consent to any act or omission intended to cause or hasten my death.
3. I instruct my Agent to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.
4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life-sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.
5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

## EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My Agent may refuse consent to health care that would not be effective in terms of my survival.
2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my Agent may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.
3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my Agent may consent to the withholding or withdrawal of life-sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.



4. If I have a total, chronic and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my Agent may consent to the withholding or withdrawal of life-sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

## **NUTRITION AND HYDRATION**

### *Food and fluids*

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.
2. A feeding tube may only be withheld or withdrawn from me if:
  - a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days;
  - b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury; or
  - c. Continuing artificially administered nutrition and hydration would hasten my death.

## **INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH**

Subject to any limitations in this document, my Agent has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.
2. Execute on my behalf any documents that may be required in order to obtain this information.
3. Consent to the disclosure of this information.

## **PREGNANT WOMEN**

If I am pregnant, the following applies:

1. My Agent is authorized to make health care decisions on behalf of my unborn child as an individual patient.
2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.
3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.
4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.
5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

**CLERGY**  
*Optional*

The Maker has requested that the Agent consult me, as the Maker's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the Agent to help meet the directives as described in this Personal Directive document and attached Addendum.

**Clergy's signature:** \_\_\_\_\_ Phone: \_\_\_\_\_

Church address: \_\_\_\_\_

**The person creating this Addendum and the witnesses must sign the document at the same time.**

**SIGNATURE OF THE MAKER**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(This signing indicates agreement with the additional directives of this Addendum.)

**NOTE: The following persons may not witness the signing of a personal directive:**

- A person designated in the directive as an agent
- The spouse or adult interdependent partner of a person designated in the directive as an agent
- The spouse or adult interdependent partner of the maker
- A person who signs the directive on behalf of the maker
- The spouse or adult interdependent partner of a person who signs the directive on behalf of the maker.

**Witness:**

Print name: \_\_\_\_\_ Date: \_\_\_\_\_

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

**Signature:** \_\_\_\_\_

I have given copies of this Personal Directive – Christian Version to:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_