~ Tennessee ~

Advance Directive and Appointment of Health Care Agent – Christian Version

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document you should know these important facts:

This document gives the person you designate as your agent (the attorney-in-fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent: (1) authorizes anything that is illegal; or (2) acts contrary to your desires as stated in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to: (1) authorize an autopsy; (2) donate your body or parts thereof for transplant; or therapeutic, educational, or scientific purposes; and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask an attorney to explain it to you.

Revised 2018; Reviewed 2023

STATE OF TENNESSEE
ADVANCE DIRECTIVE

Written in accordance with Tennessee Code § 34-6-203 to § 34-6-218.

Document made this _____ day of _____, _____.
Month Year

CREATION OF ADVANCE DIRECTIVE

I, _____, _____
Print full legal name Street

_____, _____, _____, _____/_____/_____, being of
City State Zip Code Date of birth
sound mind, intend by this document to create an advance directive for health care. My executing this advance directive is voluntary. Despite the creation of this advance directive, 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 the purposes of this document, "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.

DESIGNATION OF AGENT

If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate

_____, _____
Agent Address

_____, (_____) _____, to be my agent for
Phone
the purpose of making health care decisions on my behalf. If he or she is ever unable or unwilling to do so, I hereby designate

_____, _____
Alternate agent Address

_____, (_____) _____, to be my alternate agent for
Phone
the purpose of making health care decisions on my behalf. Neither my agent nor my alternate agent whom I have designated, is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient or a spouse of any of those persons, unless he or she is also my relative. For purposes of this document, "incapacity" exists if two (2) physicians or a physician and a psychologist who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions. A copy of that statement must be attached to this document.

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my agent and believe that he or she understands any philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my agent under this document.

WHEN EFFECTIVE

If I am unable, due to my incapacity, to participate in making a health care decision, my agent is instructed to make the health care decision for me, but my agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my agent shall base his or her health care decision on what he or she believes to be in my best interest.

OTHER INSTRUCTIONS

Such as Burial Arrangements, Hospice Care, Etc.

Optional

_____

_____

_____

[Attach additional pages, if needed]

LIMITATIONS ON MENTAL HEALTH TREATMENT

My agent may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, 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.

ADMISSION TO NURSING HOMES

My agent may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my agent may not so admit me:

A nursing home **Yes** ❑ **No** ❑ (SEE ADDENDUM – pages 8-11)

If I have not checked either "Yes" or "No" immediately above, my agent may only admit me for short–term stays for recuperative care or respite care.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my agent may not have a feeding tube withheld or withdrawn from me.

My agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes** ❑ **No** ❑ (SEE ADDENDUM – pages 8-11)

If I have not checked either "Yes" or "No" immediately above, my agent may not have a feeding tube withheld or withdrawn from me.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my agent may not make health care decisions for me if my agent knows I am pregnant.

Health care decision if I am pregnant **Yes** ❑ **No** ❑ (SEE ADDENDUM – pages 8-11)

If I have not checked either "Yes" or "No" immediately above, my agent may not make health care decisions for me if he or she knows I am pregnant.

In no event is my agent authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

In exercising authority under this document, my agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions, or limitations that I wish to state (add more items as appropriate):

1. I request that the attached Addendum (pages 8-11) be included as a valid part of this Advance Directive document.

2. I request, but not as a requirement, that my agent consult my clergy regarding health care decisions.

3. _____

_____

_____

_____

[Attach additional pages, if needed]

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.

HIPAA RELEASE STATEMENT

I intend for my agent to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my agent the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

ANATOMICAL GIFTS

Optional

Upon my death:

_____ I wish to donate only the following organs or parts:

_____

_____

_____

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study if needed.

_____ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failure to check any of the lines immediately above creates no presumption about my desire to make or refusal to make an anatomical gift.

Signature: _____ Date: _____

The principal and the two adult witnesses (or notary) must sign the document at the same time. Your signature must either be witnessed by two competent adults (OPTION A, below) or notarized (OPTION B, below). If witnessed, either witness may be the person you appointed as your agent, and at least one of the witnesses must be someone who is not related to you by blood, marriage, or adoption or entitled to any part of your estate.

SIGNATURE OF PRINCIPAL

(Person creating this Advance Directive)

Signature: _____ Date: _____

(The signing of this document by the principal revokes all previous advance directive for health care documents.)

OPTION A: STATEMENT OF WITNESSES

I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

Witness #1

Print name: _____ Date: _____

Address: _____

Witness #1 Signature: _____

I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption, and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by option of law. I witnessed the patient's signature on this form.

Witness #2

Print name: _____ Date: _____

Address: _____

Witness #2 Signature: _____

OPTION B: STATEMENT OF NOTARY PUBLIC

This document may be notarized instead of witnessed.

State of Tennessee
County of _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "Principal." The Principal personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the Principal appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Signature of Notary Public

My commission expires: _____

STATEMENT OF AGENT

I understand that _____ has designated me to be his or her health care
Name of principal
agent if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

_____ has discussed his or her desires regarding health care decisions
Name of principal
with me.

Agent's signature: _____

Address: _____

STATEMENT OF ALTERNATE AGENT

I understand that _____ has designated me to be his or her alternate
Name of principal
agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as agent is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions
Name of principal
with me.

Alternate agent's signature: _____

Address: _____

ADDENDUM TO THE TENNESSEE ADVANCE 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 begins 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. If I have checked "Yes" to the "Withhold or withdraw a feeding tube" option in the "PROVISION OF FEEDING TUBE" section of the Advance Directive document, then 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, and
   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.

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.

The principal and the two adult witnesses (or notary) must sign the document at the same time. Your signature must either be witnessed by two competent adults (OPTION A, below) or notarized (OPTION B, below). If witnessed, either witness may be the person you appointed as your agent, and at least one of the witnesses must be someone who is not related to you by blood, marriage, or adoption or entitled to any part of your estate.

SIGNATURE OF PRINCIPAL

(Person creating this Advance Directive)

Signature: _____ Date: _____

(The signing of this document by the principal revokes all previous advance directives for health care documents.)

OPTION A: STATEMENT OF WITNESSES

I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

Witness #1

Print name: _____ Date: _____

Address: _____

Witness #1 Signature: _____

I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by option of law. I witnessed the patient's signature on this form.

Witness #2

Print name: _____ Date: _____

Address: _____

Witness #2 Signature: _____

OPTION B: STATEMENT OF NOTARY PUBLIC

This document may be notarized instead of witnessed.

State of Tennessee
County of _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "Principal." The Principal personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the Principal appears to be of sound mind and under no duress, fraud, or undue influence.

_____
Signature of Notary Public

My commission expires: _____

STATEMENT OF AGENT

I understand that _____ has designated me to be his or her health care
Name of principal
agent if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself.

_____ has discussed his or her desires regarding health care decisions
Name of principal
with me.

Agent's signature: _____

Address: _____

STATEMENT OF ALTERNATE AGENT

I understand that _____ has designated me to be his or her alternate
Name of principal
agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as agent is unable or unwilling to make those decisions.

_____ has discussed his or her desires regarding health care decisions
Name of principal
with me.

Alternate agent's signature: _____

Address: _____

CLERGY
Optional

The principal has requested that the agent consult me, as the principal'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 Advance Directive document and attached Addendum.

Clergy's signature:_____ Phone: (____) _____

Church address: _____

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

_____ _____

_____ _____

_____ _____