Sunshine
Health Care Center

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Advance Directive Form

I, (*print your name*) _____, write this document as a directive regarding my medical care.

1. My Durable Power of Attorney for Health Care

Choose only one by initialing the blank space before your choice.

_____ **YES**, I want appoint the following person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself. I want the person I have appointed, my doctor, my family and others to be guided by the decisions I have made in the part of the form that follows.

Full Name _____

Address _____

Home Phone _____ Work Phone _____

If the person above cannot or will not make decisions for me, I appoint the following person in his/her stead:

Full Name _____

Address _____

Home Phone _____ Work Phone _____

_____ **NO**, I have not appointed anyone to make health care decisions for me in this or any other document, nor do I wish to at this time.

Patient Signature _____ Date _____