

## INTRODUCTION TO YOUR GEORGIA ADVANCE DIRECTIVE

This packet contains two legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself:

1. The **Georgia Durable Power of Attorney for Health Care** lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. The Durable Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.
2. The **Georgia Living Will** lets you state your wishes about medical care in the event that you are terminally ill, in a persistent vegetative state or coma and can no longer make your own medical decisions. Your diagnosis must be certified in writing by your doctor and one other physician.

*Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).*

## GEORGIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

**Whom should I appoint as my agent?** Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent can be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. An agent may also be called an “attorney-in-fact” or “proxy.” No health care provider may act as your agent if he or she is directly or indirectly involved in your health care.

You can appoint a second and third person as your alternate agent(s). The alternate will step in if the first person you name as agent is unable, unwilling or unavailable to act for you.

### **How do I make my Georgia Durable Power of Attorney for Health Care legal?**

The law requires that you sign your document, or direct another to sign it, in the presence of two witnesses who must be at least 18 years of age. If you are a patient in a hospital or skilled nursing facility, your document must also be signed in the presence of your doctor.

*Note: You do not need to notarize your Georgia Durable Power of Attorney for Health Care.*

### **Should I add personal instructions to my Georgia Durable Power of Attorney for Health Care?**

Caring Connections advises you not to add instructions to this document. One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add

instructions to this document, you might unintentionally restrict your agent’s power to act in your best interest. Instead, we urge you to talk with your agent about your future medical care and describe what you consider to be an acceptable “quality of life.” If you want to record your wishes about specific treatments or conditions, you should use your Georgia Living Will.

### **What if I change my mind?**

You may revoke your Georgia Durable Power of Attorney for Health Care at any time, regardless of your mental or physical condition, by:

- obliterating, burning, tearing, or otherwise destroying or defacing your document,
- signing and dating a written revocation or directing another person to do so, or
- orally revoking your document in the presence of a witness, at least 18 years of age, who must sign and date a written confirmation of your revocation within 30 days.

If you get married after completing a Durable Power of Attorney for Health Care in which you have not named your spouse as your agent, your marriage automatically revokes the power of your agent. If you have appointed your spouse as your agent and your marriage ends, your agent’s power is automatically revoked.

### **What other important facts should I know?**

Section 6 of your Durable Power of Attorney for Health Care provides space where you can nominate someone to serve as your guardian if there should come a time when you need a court-appointed guardian. Unless a court specifies otherwise, your guardian has no power to make any personal or health care decisions granted to your agent under your Durable Power of Attorney for Health Care.

## COMPLETING YOUR GEORGIA LIVING WILL

### How do I make my Living Will legal?

The law requires that you sign your Living Will in the presence of two witnesses, who must also sign the document to show that they personally know you and believe you to be of sound mind, that you signed the document in their presence, that they are 18 years of age or older, and that they do not fall into any of the categories of people who cannot be witnesses.

These witnesses **cannot**:

- be related to you by blood or marriage,
- be financially responsible for your medical care,
- be entitled to any part of your estate upon your death,
- have a claim against any portion of your estate,
- be your doctor or a person employed by your doctor, or
- be an employee of a health care facility in which you are a patient.

If you are a patient in a hospital or skilled nursing facility, you are required to have a third witness. If you are in a hospital, this third witness must be either the chief of the medical staff, a staff physician, or another person designated by the hospital administrator. If you are in a skilled nursing facility, this third witness must be either the medical director or a physician on the medical staff. Your third witness cannot be involved in your medical care.

*Note: You do not need to notarize your Georgia Living Will.*

### Can I add personal instructions to my Living Will?

Yes. You can add personal instructions in the part of the document called “Other directions.” For example, you may want to refuse specific treatments by a statement such as, “I especially do not want cardiopulmonary resuscitation, a respirator or antibiotics.” You may also want to

emphasize pain control by adding instructions such as, “I want to receive as much pain medication as necessary to ensure my comfort, even if it may hasten my death.” If you want to refuse artificial nutrition, artificial hydration or both, you must check the appropriate options in section 1. If you have appointed an agent and you want to add personal instructions to your Living Will, it is a good idea to write a statement such as, “Any questions about how to interpret or when to apply my Living Will are to be decided by my agent.”

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor or order the Caring Connections booklet, “Advance Directives and End-of-Life Decisions.”

### What if I change my mind?

You can revoke your Georgia Living Will at any time, regardless of your mental condition, by:

- destroying the document,
- signing and dating a written revocation, or directing another person to do so in your presence, or
- orally or otherwise expressing your intent to revoke your Living Will.

Your doctor must be notified of your revocation for it to be effective.

### What other important facts should I know?

If you are a woman of childbearing age and would like your Georgia Living Will to be honored even if you are pregnant, you must initial the statement in paragraph 5 of the Living Will form.

State law requires that before honoring a pregnant patient’s Living Will, the attending physician must first determine whether the fetus is viable. If the fetus is viable, your Living Will will not be honored, even if you initial paragraph 5.

## **AFTER YOU HAVE COMPLETED YOUR DOCUMENTS**

1. Your Georgia Durable Power of Attorney for Health Care and Georgia Living Will are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your agent and alternate agents, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your agent and alternates, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.
5. Remember, you can always revoke one or both of your Georgia documents.
6. Be aware that your Georgia documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called “non-hospital do-not-resuscitate orders,” are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop. Currently not all states have laws authorizing nonhospital do-not-resuscitate orders. Caring Connections does not distribute these forms. We suggest you speak to your physician.

**GEORGIA STATUTORY SHORT FORM DURABLE POWER OF ATTORNEY FOR  
HEALTH CARE – PAGE 1 OF 6**

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NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR AGENT) BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU, INCLUDING POWER TO REQUIRE, CONSENT TO, OR WITHDRAW ANY TYPE OF PERSONAL CARE OR MEDICAL TREATMENT FOR ANY PHYSICAL OR MENTAL CONDITION AND TO ADMIT YOU TO OR DISCHARGE YOU FROM ANY HOSPITAL, HOME, OR OTHER INSTITUTION; BUT NOT INCLUDING PSYCHOSURGERY, STERILIZATION, OR INVOLUNTARY HOSPITALIZATION OR TREATMENT COVERED BY TITLE 37 OF THE OFFICIAL CODE OF GEORGIA ANNOTATED. THIS FORM DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS; BUT, WHEN A POWER IS EXERCISED, YOUR AGENT WILL HAVE TO USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS FORM. A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THE AGENT IS NOT ACTING PROPERLY. YOU MAY NAME COAGENTS AND SUCCESSOR AGENTS UNDER THIS FORM, BUT YOU MAY NOT NAME A HEALTH CARE PROVIDER WHO MAY BE DIRECTLY OR INDIRECTLY INVOLVED IN RENDERING HEALTH CARE TO YOU UNDER THIS POWER. UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THIS POWER IN THE MANNER PROVIDED BELOW OR UNTIL YOU REVOKE THIS POWER OR A COURT ACTING ON YOUR BEHALF TERMINATES IT, YOUR AGENT MAY EXERCISE THE POWERS GIVEN IN THIS POWER THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME DISABLED, INCAPACITATED, OR INCOMPETENT. THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO REVOKE THOSE POWERS, AND THE PENALTIES FOR VIOLATING THE LAW ARE EXPLAINED MORE FULLY IN CODE SECTIONS 31-36-6, 31-36-9, AND 31-36-10 OF THE GEORGIA 'DURABLE POWER OF ATTORNEY FOR HEALTH CARE ACT' OF WHICH THIS FORM IS A PART. THAT ACT EXPRESSLY PERMITS THE USE OF ANY DIFFERENT FORM OF POWER OF ATTORNEY YOU MAY DESIRE.

IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

**GEORGIA STATUTORY SHORT FORM DURABLE POWER OF  
ATTORNEY FOR HEALTH CARE - PAGE 2 OF 6**

INSTRUCTIONS

PRINT THE DATE

DURABLE POWER OF ATTORNEY made this \_\_\_\_\_ day of, 20\_\_\_\_.

PRINT YOUR NAME  
AND ADDRESS

1. I, \_\_\_\_\_  
(name)

\_\_\_\_\_  
(address)

hereby appoint \_\_\_\_\_  
(name of agent)

\_\_\_\_\_  
(address)

PRINT THE NAME  
AND ADDRESS OF  
YOUR AGENT

as my attorney in fact (my agent) to act for me and in my name in any way I could act in person to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and health care and to require, withhold, or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any part or all of my body for medical purposes, authorize an autopsy of my body, and direct the disposition of my remains.

THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF NOURISHMENT AND FLUIDS AND OTHER LIFE-SUSTAINING OR DEATH-DELAYING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT'S POWERS OR PRESCRIBE SPECIAL RULES TO LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY, OR DISPOSE OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.

**GEORGIA STATUTORY SHORT FORM DURABLE POWER OF  
ATTORNEY FOR HEALTH CARE - PAGE 3 OF 6**

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ADD LIMITATIONS  
AND SPECIAL  
PROVISIONS TO  
YOUR AGENT'S  
POWER  
(OPTIONAL)

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as your own definition of when life-sustaining or death-delaying measures should be withheld; a direction to continue nourishment and fluids or other life-sustaining or death-delaying treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electro convulsive therapy, or amputation):

THE SUBJECT OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT, BUT DO NOT INITIAL MORE THAN ONE:

INITIAL THE ONE  
STATEMENT THAT  
REFLECTS YOUR  
WISH

\_\_\_\_\_ I do not want my life to be prolonged nor do I want life-sustaining or death-delaying treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining or death-delaying treatment.

\_\_\_\_\_ I want my life to be prolonged and I want life-sustaining or death-delaying treatment to be provided or continued unless I am in a coma, including a persistent vegetative state, which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered such an irreversible coma, I want life sustaining or death-delaying treatment to be withheld or discontinued.

\_\_\_\_\_ I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures.

**GEORGIA STATUTORY SHORT FORM DURABLE POWER OF  
ATTORNEY FOR HEALTH CARE - PAGE 4 OF 6**

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THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU AT ANY TIME AND IN ANY MANNER WHILE YOU ARE ABLE TO DO SO. IN THE ABSENCE OF AN AMENDMENT OR REVOCATION, THE AUTHORITY GRANTED IN THIS POWER OF ATTORNEY WILL BECOME EFFECTIVE AT THE TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH AND WILL CONTINUE BEYOND YOUR DEATH IF ANATOMICAL GIFT, AUTOPSY, OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:

INITIAL AND PRINT  
EFFECTIVE DATE  
(OPTIONAL)

3. (     ) This power of attorney shall become effective on\_\_\_\_\_.  
(Insert a future date or event during your lifetime, such as court determination of your disability, incapacity, or incompetency, when you want this power to first take effect.)

INITIAL AND PRINT  
EXPIRATION     DATE  
(OPTIONAL)

4. (     ) This power of attorney shall terminate on\_\_\_\_\_.  
Insert a future date or event, such as court determination of your disability, incapacity, or incompetency, when you want this power to terminate prior to your death.)

IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND ADDRESSES OF SUCH SUCCESSORS IN THE FOLLOWING PARAGRAPH:

PRINT THE NAME  
AND ADDRESS OF  
YOUR ALTERNATE  
AGENTS  
(OPTIONAL)

5. If any agent named by me shall die, become legally disabled, incapacitated, or incompetent, or resign, refuse to act, or be unavailable, I name the following (each to act successively in the order named) as successors to such agent:

FIRST  
ALTERNATE

1. Name \_\_\_\_\_  
Address \_\_\_\_\_

SECOND  
ALTERNATE

2. Name \_\_\_\_\_  
Address \_\_\_\_\_

**GEORGIA STATUTORY SHORT FORM DURABLE POWER OF  
ATTORNEY FOR HEALTH CARE — PAGE 5 OF 6**

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IF YOU WISH TO NAME A GUARDIAN OF YOUR PERSON IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED, YOU MAY, BUT ARE NOT REQUIRED TO, DO SO BY INSERTING THE NAME OF SUCH GUARDIAN IN THE FOLLOWING PARAGRAPH. THE COURT WILL APPOINT THE PERSON NOMINATED BY YOU IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. YOU MAY, BUT ARE NOT REQUIRED TO, NOMINATE AS YOUR GUARDIAN THE SAME PERSON NAMED IN THIS FORM AS YOUR AGENT.

PRINT THE NAME  
AND ADDRESS OF  
A GUARDIAN  
(OPTIONAL)

6. If a guardian of my person is to be appointed, I nominate the following to serve as such guardian: \_\_\_\_\_  
(name of guardian)

\_\_\_\_\_  
(address)

SIGN THE  
DOCUMENT

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed: \_\_\_\_\_  
(principal)

WITNESSING  
PROCEDURES

The principal has had an opportunity to read the above form and has signed the above form in our presence. We, the undersigned, each being over 18 years of age, witness the principal's signature at the request and in the presence of the principal, and in the presence of each other, on the day and year above set out.

Witness: \_\_\_\_\_

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

YOUR TWO  
WITNESSES MUST  
SIGN AND PRINT  
THEIR ADDRESSES

Witness: \_\_\_\_\_

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

**GEORGIA STATUTORY SHORT FORM DURABLE POWER OF  
ATTORNEY FOR HEALTH CARE — PAGE 6 OF 6**

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RESIDENTS OF A  
HOSPITAL OR  
NURSING HOME  
NEED ONE  
ADDITIONAL  
WITNESS

Additional witness required when health care agency is signed in a hospital or skilled nursing facility. I hereby witness this health care agency and attest that I believe the principal to be of sound mind and to have made this health care agency willingly and voluntarily.

Witness (Attending Physician) \_\_\_\_\_  
(signature)

Address \_\_\_\_\_

YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.

Specimen signatures of  
agent and successor(s)

I certify that the signature of my  
agent and successor(s) is correct

\_\_\_\_\_  
(agent) (principal)

\_\_\_\_\_  
(successor agent) (principal)

\_\_\_\_\_  
(successor agent) (principal)

SAMPLE  
SIGNATURES OF  
YOUR AGENT AND  
ALTERNATES  
(OPTIONAL)

**GEORGIA LIVING WILL PAGE 1 OF 3**

INSTRUCTIONS

PRINT THE DATE

Living will made this \_\_\_\_\_ day of \_\_\_\_\_  
(date) (month, year)

PRINT YOUR NAME

I, \_\_\_\_\_  
(name)

being of sound mind, willfully and voluntarily make known my desire that my life shall not be prolonged under the circumstances set forth below and do declare:

CHECK THE  
OPTIONS THAT  
APPLY

1. If at any time I should (check each option desired):

( ) have a terminal condition,

( ) become in a coma with no reasonable expectation of regaining consciousness, or

( ) become in a persistent vegetative state with no reasonable expectation of regaining significant cognitive function,

as defined in and established in accordance with the procedures set forth in paragraphs (2), (9), and (13) of Code Section 31-32-2 of the Official Code of Georgia Annotated, I direct that the application of life-sustaining procedures to my body be withheld or withdrawn and that I be permitted to die.

CHECK THE  
OPTIONS THAT  
REFLECT YOUR  
WISHES ABOUT  
ARTIFICIAL  
FEEDING

With regard to artificially supplied nutrition and hydration, I direct that:

(check the option desired)

( ) artificial nutrition be provided.

( ) artificial nutrition be withheld or withdrawn.

(check the option desired)

( ) artificial hydration be provided.

( ) artificial hydration be withheld or withdrawn.

ADD PERSONAL  
INSTRUCTIONS  
(IF ANY)

Other directions:

**GEORGIA LIVING WILL — PAGE 2 OF 3**

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2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this living will shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal;
3. I understand that I may revoke this living will at any time;
4. I understand the full import of this living will, and I am at least 18 years of age and am emotionally and mentally competent to make this living will; and
5. If I am a female and I have been diagnosed as pregnant, I want this living will to be carried out despite my pregnancy. \_\_\_\_\_(initial)

INITIAL THIS STATEMENT IF IT REFLECTS YOUR WISHES

SIGN THE DOCUMENT AND PRINT YOUR CITY, COUNTY AND STATE OF RESIDENCE

Signed \_\_\_\_\_

City \_\_\_\_\_

County \_\_\_\_\_

State of Residence \_\_\_\_\_

WITNESSING PROCEDURE

WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES ON THE FOLLOWING PAGE

I hereby witness this living will and attest that:

- (1) The declarant is personally known to me and I believe the declarant to be at least 18 years of age and of sound mind;
- (2) I am at least 18 years of age;
- (3) To the best of my knowledge, at the time of the execution of this living will, I:
  - a) Am not related to the declarant by blood or marriage;
  - b) Would not be entitled to any portion of the declarant's estate by any will or by operation of law under the rules of descent and distribution of this state;
  - c) Am not the attending physician of declarant or an employee of the attending physician or an employee of the hospital or skilled nursing facility in which declarant is a patient;
  - d) Am not directly financially responsible for the declarant's medical care; and
  - e) Have no present claim against any portion of the estate of the declarant;

**GEORGIA LIVING WILL — PAGE 3 OF 3**

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(4) Declarant has signed this document in my presence as above instructed, on the date above first shown.

WITNESS #1

Witness \_\_\_\_\_

Address \_\_\_\_\_

WITNESS #2

Witness \_\_\_\_\_

Address \_\_\_\_\_

Additional witness required when living will is signed by a patient in a hospital or skilled nursing facility.

I hereby witness this living will and attest that I believe the declarant to be of sound mind and to have made this living will willingly and voluntarily.

RESIDENTS OF A  
HOSPITAL OR  
NURSING HOME  
MUST HAVE ONE  
ADDITIONAL  
WITNESS

Witness \_\_\_\_\_

(Medical director of skilled nursing facility or staff physician not participating in care of the patient, or chief of the hospital medical staff or staff physician or hospital designee not participating in care of the patient.)