Montana Department of Justice
Office of Consumer Protection
MONTANA
END-OF-LIFE REGISTRY
www.doj.mt.gov/consumer/consumer

My Choices Advance Directive

For office use only

2225 11th Avenue, PO Box 201410, Helena, MT 59620-1410 • Phone: (406) 444-0660 or (866) 675-3314 • E-mail: endofliferegistry@mt.gov

Full Name: _____
Please print

These directions apply only in situations when I am not able to make or communicate my health care choices directly. Put an X through any sections you are not completing at this time.

1. Terminal Conditions (Living Will)

I provide these directions in accordance with the Montana Rights of the Terminally Ill Act. These are my wishes for the kind of treatment I want if I cannot communicate or make my own decisions. These directions are only valid if both of the following two conditions exist:

- **I have a terminal condition, and**
- **in the opinion of my attending physician, I will die in a relatively short time without life sustaining treatment that only prolongs the dying process.**

I authorize my Representative, if I have appointed one, to make the decision to provide, withhold, or withdraw any health care treatment.

General Treatment Directions

Check the boxes that express your wishes:

☐ I provide no directions at this time.

☐ I direct my attending physician to withdraw or withhold treatment that merely prolongs the dying process.

I further direct that (check all boxes that apply):

☐ Treatment be given to maintain my dignity, keep me comfortable and relieve pain even if it shortens my life.

☐ If I cannot drink, I do not want to receive fluids through a needle or catheter placed in my body unless for comfort.

☐ If I cannot eat, I do not want a tube inserted in my nose or mouth, or surgically placed in my stomach to give me food.

☐ If I have a serious infection, I do not want antibiotics to prolong my life. Antibiotics may be used to treat a painful infection.

I have attached additional directions regarding medical treatment to this form:

☐ Yes ☐ No

2. Chronic Illness or Serious Disability (Optional)

My chronic illness or disability can complicate an acute illness, but should not be misinterpreted as a terminal condition.

Diagnosis _____

Consult my physician _____
Name Phone

Special directions (use additional pages if necessary) _____

3. Health Care Representative (Power of Attorney for Health Care)

My Representative may make all health care decisions for me as authorized in this document and shall be given access to all my medical records. This appointment applies whether I am expected to recover or not.

I wish to appoint a Representative ☐ Yes ☐ No

A. Primary Representative

I appoint _____ as my Representative.
Print Representative's Full Name

_____
Representative's Address

_____
City State Zip

_____
Home Phone Work Phone

My Representative's authority is effective when I cannot make health care decisions or communicate my wishes. I may revoke this authority at any time I regain these abilities (unless my attending physician and any necessary experts determine I am not capable of making decisions in my own best interest).

If, for any reason, I should need a guardian of my person designated by a court, I nominate my Representative, or Alternate Representative(s), named below.

B. Alternate Representative(s)

If: 1. I revoke my Representative's authority; or
2. My Representative becomes unwilling or unable to act for me; or
3. My Representative is my spouse and I become legally separated or divorced,

I name the following person(s) as alternates to my Representative in the order listed:

1. _____
Print Alternate Representative's Full Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

2. _____
Print Alternate Representative's Full Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

4. Signing and Witnessing this Advance Directive

A. Your Signature

Ask two people to watch you sign and have them sign below. If you can, it's best to sign this document in front of a Notary Public.

1. I revoke any prior health care advance directive or directions.
2. This document is intended to be valid in any jurisdiction in which it is presented.
3. A copy of this document is intended to have the same effect as the original.
4. Those who act as I have directed in this document shall be free from legal liability for having followed my directions.
5. If my attending physician is unwilling or unable to comply with my wishes as stated in this document, I direct my care be transferred to a physician who will.

I sign this document on the _____ day of _____, 20_____

_____ _____

Signature Print Full Name

_____

Address

_____

City State Zip

_____

Home Phone Work Phone

B. Ask Your Witnesses to Read and Sign

I declare that I am over the age of 18 and the person who signed this document is personally known to me, and has signed these health care advance directives in my presence, and appears to be of sound mind and under no duress, fraud or undue influence.

1. _____ **2.** _____

Signature Date Signature Date

_____ _____

Printed Name Printed Name

_____ _____

Address Address

_____ _____

City State Zip City State Zip

C. Notarizing This Document

STATE OF _____ COUNTY OF _____

On this _____ day of _____, 20____, the said known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public within and for the State and County aforesaid, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.

_____

_____

Notary Public for the State of _____

Residing at _____

My commission expires _____

5. Special Directions

A. Spiritual Preferences

My religion _____ My faith community _____

Contact person _____ I would like spiritual support ☐ Yes ☐ No

B. Where I Would Like to be When I Die

☐ My home ☐ Hospital ☐ Nursing home ☐ Other _____

C. Donation of Organs at My Death (check one of the following):

☐ I do not wish to donate any of my body, organs, or tissue.

☐ I wish to donate my entire body.

☐ I wish to donate **only** the following (check all that apply):

☐ Any organs, tissues, or body parts ☐ Heart ☐ Kidneys ☐ Lungs

☐ Bone Marrow ☐ Eyes ☐ Skin ☐ Liver ☐ Other(s)

D. After-Death Care (care of my body, burial, cremation, funeral home preference)

_____

E. Additional Directions (use additional pages if necessary)

Signature _____ **Date** _____

F. Distributing this Advance Directive

I plan to deposit this Advance Directive in the Montana End-of-Life Registry: ☐Yes ☐No

I plan to send copies of this document to the following people or locations:

Physician:

_____
Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

Family Member: Relationship _____

_____
Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

Hospital:

_____
Name

_____
Address

_____
City State Zip

_____
Phone

Clergy:

_____
Name

_____
Address

_____
City State Zip

_____
Home Phone Work Phone

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Consumer Registration Agreement

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This form indicates your desire to store an advance directive in the Montana End-of-Life Registry, to replace or remove an Advance Directive already in the Registry, or to request a replacement wallet card.

- Read this Agreement carefully and fill in Sections A through C completely.
- Attach your witnessed Advance Directive.
- Return this Agreement with your Advance Directive to the Office of Consumer Protection at the address above.
- Your Consumer Registration Agreement will be processed within three weeks. You will receive further information in the mail.

Section A

Prefix	First Name	Middle Name or Initial	Last Name	Suffix

Gender	Date of Birth (Month/Day/Year)	Mother's Maiden Name	Social Security Number	Phone Number

Mailing Address				
City	**State**	**Zip**	**County**	**Country**

Section B

Pick a level of privacy:

☐ **Standard Privacy:** If the information on my wallet card is unavailable, in addition to health care providers, people who enter my Social Security Number, date of birth and mother's maiden name can view my advance directive.

☐ **Higher Privacy:** Only people who have the information from my wallet card and health care providers can view my advance directive.

I want to:

☐ **Store an advance directive in the Registry.**

☐ **Replace an advance directive in the Registry with a new one.**

☐ **Remove my advance directive from the Registry.**

☐ **Request a replacement wallet card.**

Section C Revised 7/07

I am providing this personal information along with my advance directive, with the understanding that my personal information will be stored in a secure Department of Justice database and will not be available to the public. I certify that the advance directive that accompanies this Agreement is my current effective advance directive and was duly executed, witnessed and acknowledged in accordance with Section 50-9-103 of the Montana Code Annotated.

I understand that:

- my advance directive will be entered in the Montana End-of-Life Registry free of charge;
- this authorization is voluntary;
- this authorization to store my advance directive in the Montana End-of-Life Registry will remain in force until I revoke it;
- I may revoke this authorization at any time by giving written notice of my revocation to the address listed above; and
- no agency, provider or individual may be held liable for any action based on this authorization before a written notice of revocation has been entered into the Registry.

_____ _____

Signature of Person Signing This Agreement Date

If the person named in the advance directive is unable to sign this form, and you have legal authority to sign for that person, please check the source of your authority and provide proof thereof. ☐ Durable Power of Attorney ☐ Court Appointed Guardian

What you should do with this Advance Directive

- Register your Estate Planning Documents for no fee at www.TheUSWillRegistry.Org
- It is suggested that you have your attorney review this form to be assured that it meets all your current state requirements.