ADVANCE DIRECTIVE AND MEDICAL POWER OF ATTORNEY INSTRUCTIONS

Disclaimer: This document is meant to help you express your wishes in a form that substantially complies with your state's requirements for an advance directive and medical power of attorney. This is not intended as legal advice and cannot answer every question you may have. This form is not regularly updated to incorporate changes in state law. Nothing can substitute for advice from your attorney and your doctor. If you have a specific question or concern, consult your doctor or attorney.

If you are 18 years or older, this form substantially complies with the requirements for the District of Columbia and the following states:

Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Vermont, Virginia, Washington, West Virginia & Wyoming

If you are currently a resident of an institution in California, Connecticut, Delaware, Georgia, New York, North Dakota, South Carolina, or Vermont, special rules apply. Contact a social worker or patient advocate at your institution for more information.

INSTRUCTIONS FOR COMPLETING THIS DOCUMENT

This document is an important legal document which you can use to communicate your wishes about medical treatment at some time in the future when you are unable to make your wishes known because of illness or injury. This document also names individuals who you want to make medical decisions for you if you are unable to make them for yourself. These wishes are usually based on personal values. This particular form is designed for people who have elected to be preserved through cryonics after legal death.

You are encouraged to discuss your values and wishes with your family or chosen spokesperson, as well as your physician. Various options are listed below. Initial the options which pertain to you and the treatment choices that best reflect your personal preferences. Provide a copy of your directive to your physician, usual hospital, and those who you appoint to make medical decisions for you if you cannot care for yourself. Consider a periodic review of this document. By periodic review, you can best assure that the directive reflects your preferences.

ADVANCE DIRECTIVE AND MEDICAL POWER OF ATTORNEY

Definitions:

"Artificial nutrition and hydration" means the provision of nutrients or fluids by a tube inserted in a vein, under the skin in the subcutaneous tissues, or in the stomach (gastrointestinal tract).

"Irreversible condition" means a condition, injury, or illness:

(1) that may be treated, but is never cured or eliminated;

(2) that leaves a person unable to care for or make decisions for the person's own self; and

(3) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

Explanation: Many serious illnesses such as cancer, failure of major organs (kidney, heart, liver, or lung), and serious brain disease such as Alzheimer's dementia may be considered irreversible early on. There is no cure, but the patient may be kept alive for prolonged periods of time if the patient receives life-sustaining treatments. Late in the course of the same illness, the disease may be considered terminal when, even with treatment, the patient is expected to die. You may wish to consider which burdens of treatment you would be willing to accept in an effort to achieve a particular outcome. This is a very personal decision that you may wish to discuss with your physician, family, or other important persons in your life.

"Life-sustaining treatment" means treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support such as mechanical breathing machines, kidney dialysis treatment, and artificial hydration and nutrition. The term does not include the administration of pain management medication, the performance of a medical procedure necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

"Terminal condition" means an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.

Explanation: Many serious illnesses may be considered irreversible early in the course of the illness, but they may not be considered terminal until the disease is fairly advanced. In thinking about terminal illness and its treatment, you again may wish to consider the relative benefits and burdens of treatment and discuss your wishes with your physician, family, or other important persons in your life.

MY INFORMATION

Name: _____

Address: _____

_____

Phone Number: _____

DIRECTIVE

I, _____, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

I have entered into an agreement dated _____ with *(initial your selection)*

_____ Alcor Life Extension Foundation, Inc., (800) 367-2228, 7895 East Acoma Drive, Suite 110, Scottsdale, AZ 85260

_____ Cryonics Institute, (586) 791-5961, 24355 Sorrentino Court, Clinton, Township, MI 48035

_____ _____
Insert name, telephone number, and address of your provider if not listed above

The entity selected above will hereafter be referred to as "Cryonics Provider." If at the time of my incapacitation, I have changed to a different Cryonics Provider than listed above, I direct that this agreement be interpreted to reference my new Cryonics Provider rather than the one indicated above.

I have a strong personal belief in cryopreservation. My agreement with my Cryonics Provider is related to the disposition of my remains after death. Immediately after my legal death, it is my desire that my human remains be donated to my Cryonics Provider without embalming or autopsy. While I strongly object to autopsy, if it is determined that an autopsy is legally necessary, it is my desire that the autopsy be conducted at a low temperature and in as non-invasive a way as possible without damaging or dissecting my brain. Nothing in this document should be construed as contrary to my arrangements with my Cryonics Provider.

IF I HAVE A TERMINAL CONDITION

If in the judgment of both my physician and another health care professional I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care, I direct the following *(choose any or all of the following by placing your initials beside your selection):*

_____ I direct that all health care decisions be guided by the objective of preserving my brain throughout the terminal and dying phase and ensuring cryopreservation can begin as soon as possible after my legal death.

_____ I direct that measures to prolong my life should only be initiated or accepted if they result in less damage to my brain.

_____ I direct that my Cryonics Provider be called as soon as possible at _____ so that, if possible, a stand-by team can be present prior to my legal death.

_____ I direct that my Cryonics Provider or the entity aiding in my cryopreservation be consulted to assist in making decisions about my care that will optimize my future cryopreservation.

Additionally, I direct the following *(provide your wishes in the space below or cross out these lines)*:

_____

_____

IF I AM IRREVERSIBLY MENTALLY DISABLED

If in the judgment of both my physician and another health care professional I am suffering with an irreversible condition so that I cannot care for myself or make decisions for myself and am expected to die without life-sustaining treatment provided in accordance with prevailing standards of care, I direct the following *(choose ONLY ONE of the following by placing your initials beside your selection):*

_____ So long as my brain is not deteriorating, I direct that life-sustaining treatment be continued until my Cryonics Provider is available to provide a stand-by team to be at my bedside as life-sustaining treatment is discontinued.

_____ So long as my brain is not deteriorating, I direct that I be kept alive in this irreversible condition using available life-sustaining treatment to include artificial nutrition and hydration.

(choose any or all of the following by placing your initials beside your selection)

_____ I direct that all health care decisions be guided by the objective of preserving my brain and ensuring cryopreservation can begin as soon as possible after my legal death.

_____ I direct that measures to prolong my life should only be initiated or accepted if they result in less damage to my brain.

_____ I direct that my Cryonics Provider be called as soon as possible at _____ so that, if possible, a stand-by team can be present prior to my legal death.

_____ I direct that my Cryonics Provider or the entity aiding in my cryopreservation be consulted to assist in making decisions about my care that will optimize my future cryopreservation.

Additionally, I direct the following *(provide your wishes in the space below or cross out these lines)*:

_____

_____

_____

OTHER SITUATIONS WHERE I AM NEAR DEATH

If neither of the two above sections apply but I am or may be near death, my primary goal is to be returned to a healthy life or to a conscious state so I can make my own health care decisions. If that is not possible or likely, I direct the following *(choose any or all of the following by placing your initials beside your selection)*:

_____ I direct that all health care decisions be guided by the objective of preserving my brain and ensuring cryopreservation can begin as soon as possible after my legal death.

_____ I direct that measures to prolong my life should only be initiated or accepted if they result in less damage to my brain.

_____ I direct that my Cryonics Provider be called as soon as possible at _____ so that, if possible, a stand-by team can be present prior to my legal death.

_____ I direct that my Cryonics Provider or the entity aiding in my cryopreservation be consulted to assist in making decisions about my care that will optimize my future cryopreservation.

Additionally, I direct the following *(provide your wishes in the space below or cross out these lines)*:

_____

_____

_____

MEDICAL POWER OF ATTORNEY

When selecting your agent, please select someone who is at least 18 years old (21 years in Colorado) and who is NOT your health care provider (including an owner or operator of a health or residential community serving you), an employee or spouse of an employee of your health care provider, OR a person who is already serving as an agent or proxy for ten or more people (unless they are also your spouse or close relative).

If I am no longer able to make my own health care decisions, I name the below individuals to make these decisions for me consistent with my directives above. This person will be my health care agent (or other term that may be used in my state, such as proxy, representative, or surrogate). This designation takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician and another health care professional. If my state has a different way of finding that I am not able to make health care choices, then my state's way should be followed.

I appoint the following to be my health care agent:

Name: _____

Address: _____

_____

Phone Number: _____

If the person designated as my agent is unable or unwilling to make health care decisions for me, or if the person designated above is divorced or legally separated from me after the date of this agreement, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order unless divorced or legally separated from me after the date of this agreement:

SECOND CHOICE:

Name: _____

Address: _____

_____

Phone Number: _____

THIRD CHOICE:

Name: _____

Address: _____

_____

Phone Number: _____

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

In addition to the limits discussed in my directive, I request my agent contact my Cryonics Provider as soon as possible at any time they believe that I have a significant chance of death or brain damage. After contacting my cryonics provider, I request that all medical decisions be made with the primary goal that I be returned to a healthy life. However, if that is not possible, I request that my agent consult with my Cryonics Provider to make health care decisions consistent with my wish to be cryopreserved as soon as possible following my legal death.

The following listed individuals have made it known to me that they are unwilling or unable to follow my wishes with regard to cryopreservation. Accordingly, I direct that the following individuals be excluded from serving as my health care agent under any circumstance (list names only below – you should only list people who might have a legal reason to assert themselves as your health care proxy. Generally, there is no need to list non-family members):

_____

_____

_____

This document should be executed before two witnesses *(and in some cases a notary)*

I, _____, direct that my doctors, my health care agents, and all others, follow my wishes as communicated in this Advance Directive and Medical Power of Attorney. This document becomes valid when I am unable to make decisions or speak for myself. If any part of this document cannot be legally followed, I ask that all other parts of this document be followed. I also revoke any health care advance directives or medical powers of attorney I have made before.

Signature:_____

Print Name:_____ Date:_____

Address: _____

Phone: _____

WITNESSES *(you should choose witnesses who can attest to the following statement)*

We, the witnesses, declare that the person who signed or acknowledged this form (hereafter "person") is personally known to me, that they acknowledged this document in my presence, and that they appear to be of sound mind and under no duress, fraud, or undue influence. Additionally, I am over 18 years of age and am not any of the following: the individual appointed as health care agent or alternate in this document, the person's health care provider, including owner or operator of a health, long-term care, or other residential or community care facility serving the person, an employee of the person's health care provider, financially responsible for the person's health care, an employee of a life or health insurance provider for the person, related to the person by blood, marriage, or adoption, to the best of my knowledge, a creditor of the person or entitled to any part of their estate under a will or codicil, or by operation of law.

We declare that the person who signed or acknowledged this form is personally known to me, that he or she signed or acknowledged this document in my presence, and that he or she appears to be of sound mind and under no duress, fraud, or undue influence.

(Not all of the above restrictions apply in every state. However, unless you know your states rules, please follow all of the above)

SIGNATURE OF FIRST WITNESS.

Signature:_____

Print Name:_____ Date:_____

Address: _____

SIGNATURE OF SECOND WITNESS.

Signature:_____

Print Name:_____ Date:_____

Address: _____

NOTARIZATION *(Required in Missouri, North Carolina, South Carolina, and West Virginia)*

For Missouri, only your signature need be notarized, in other states, you should have your signature and the signatures of your witnesses notarized.

STATE OF _____

COUNTY OF_____

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

My Commission Expires:

_____
Notary Public