

# Advance Health Care Directive



Use of this form is optional; an Advance Health Care Directive is equally valid whether or not this form is used.

## This is the Advance Health Care Directive of:

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Telephone \_\_\_\_\_

## Part 1 – Designation of a Health Care Proxy

You may name one or more persons who will have the power to make decisions about your medical treatment when you are unable to make those decisions yourself. You may skip this part if you do not wish to name a proxy.

I hereby designate the following person(s) as my Health Care Proxy:

### Proxy 1

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Telephone \_\_\_\_\_

### Proxy 2

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Telephone \_\_\_\_\_

### Proxy 3

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Telephone \_\_\_\_\_



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## Part 3 – Values and beliefs

In this part, you may describe your values, beliefs and wishes in general terms to guide decision-making by health-care providers and your proxy (if you have chosen to appoint a proxy).

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## Part 4 – Signature and date

Your advance health care directive is complete once you and a witness sign it. If you are unable to sign, a substitute may sign on your behalf. The substitute must sign in your presence and in the presence of a witness. The proxy or the proxy's spouse cannot be the substitute or witness.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name of substitute \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Witness

The directive must be signed by a witness who is at least 19 years of age.

Name of witness \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_