



A Professional Corporation

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**Health Care Advance Directive**

1. When would you want the document to become effective? \_\_\_\_\_ Immediately  
\_\_\_\_\_ Upon incapacity \_\_\_\_\_ On and after a specific date.
2. Who would you like to appoint as your representatives in the event the directive is utilized?
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
3. Do you want your named appointees to serve alone? Y/N or  
Do your appointees need collaborate in any decision making? Y/N  
Who would be the tie breaker if the appointees disagree? \_\_\_\_\_
4. Do you wish for your appointee to have the authority to make decisions regarding the  
provision or withdrawal of life prolonging procedures? Y/N
5. Do you wish for your appointee to make decisions or be able to give instructions regarding  
the disposition of your remains? Y/N
6. If there is reasonable certainty that you are terminally ill or in a persistent and irreversible  
coma consider your wishes in the event of the following:

If you have no pulse and are not breathing, should resuscitation be attempted? Y/N

Should your comfort be maximized through symptom management and relieve any pain  
and suffering through available measures, including the administration of medication  
through any route? Y/N

Would you wish to prolong your life with the administration of artificial nutrition or  
hydration? Y/N

Would you wish to be transferred from your current location to a different hospital for  
life sustaining treatment? Y/N

7. Would you wish to grant your appointee any additional powers such as:

The authority to consent on your behalf to mental health treatment? Y/N

The authority to collect reasonable compensation for their services? Y/N

8. Would you like to provide any additional explicit instructions regarding your health care decisions to your appointee?

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