UNOFFICIAL COPY OF SENATE BILL 369

J1 (6lr2183)

ENROLLED BILL

-- Education, Health, and Environmental Affairs/Health and Government Operations --

Introduced by **Senator Hollinger**

Read and Examined by Proofreaders:

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Proofreader.

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Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this _____ day of ____________ at ____________________ o'clock, _____M.

____
President.

CHAPTER_______

1 AN ACT concerning

2 **Health Care Decisions Act - Advance Directives - Selection of Health Care**
3 **Agent and Treatment Preferences**

4 FOR the purpose of clarifying certain forms relating to the selection of certain health
5 care agents, certain treatment preferences, and certain donations; clarifying
6 that certain surrogate decision-makers may make certain decisions when
7 certain health care agents are unavailable; ~~authorizing certain certifications of~~
8 ~~incapacity to be made by certain physicians or certain psychologists~~ ~~nurse~~
9 ~~practitioners;~~ repealing a certain provision;~~ defining certain terms~~ *altering a*
10 *certain definition*; and generally relating to the Health Care Decisions Act.

11 BY repealing
12 Article - Health - General
13 Section 5-603
14 Annotated Code of Maryland
15 (2005 Replacement Volume and 2005 Supplement)

1 BY adding to
2 Article - Health - General
3 Section 5-603
4 Annotated Code of Maryland
5 (2005 Replacement Volume and 2005 Supplement)

6 BY repealing and reenacting, with amendments,
7 Article - Health - General
8 Section 5-605(a)(1) and (2) ~~and 5-606(a)~~
9 Annotated Code of Maryland
10 (2005 Replacement Volume and 2005 Supplement)

11 SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF
12 MARYLAND, That Section(s) 5-603 of the Health - General Article of the Annotated
13 Code of Maryland be repealed.

14 SECTION 2. AND BE IT FURTHER ENACTED, That the Laws of Maryland
15 read as follows:

16 **Article - Health - General**

17 5-603.

18 MARYLAND ADVANCE DIRECTIVE:
19 PLANNING FOR FUTURE HEALTH CARE DECISIONS

20 BY: __________________________ DATE OF BIRTH: ____________________
21 (PRINT NAME) (MONTH/DAY/YEAR)

22 USING THIS ADVANCE DIRECTIVE FORM TO DO HEALTH CARE PLANNING IS
23 COMPLETELY OPTIONAL. OTHER FORMS ARE ALSO VALID IN MARYLAND. NO MATTER
24 WHAT FORM YOU USE, TALK TO YOUR FAMILY AND OTHERS CLOSE TO YOU ABOUT
25 YOUR WISHES.

26 THIS FORM HAS TWO PARTS TO STATE YOUR WISHES, AND A THIRD PART FOR
27 NEEDED SIGNATURES. PART I OF THIS FORM LETS YOU ANSWER THIS QUESTION: IF
28 YOU CANNOT (OR DO NOT WANT TO) MAKE YOUR OWN HEALTH CARE DECISIONS,
29 WHO DO YOU WANT TO MAKE THEM FOR YOU? THE PERSON YOU PICK IS CALLED
30 YOUR HEALTH CARE AGENT. **MAKE SURE YOU TALK TO YOUR HEALTH CARE**
31 **AGENT (AND ANY BACK-UP AGENTS) ABOUT THIS IMPORTANT ROLE**. PART II LETS
32 YOU WRITE YOUR PREFERENCES ABOUT EFFORTS TO EXTEND YOUR LIFE IN THREE
33 SITUATIONS: TERMINAL CONDITION, PERSISTENT VEGETATIVE STATE, AND
34 END-STAGE CONDITION. IN ADDITION TO YOUR HEALTH CARE PLANNING
35 DECISIONS, YOU CAN CHOOSE TO BECOME AN ORGAN DONOR AFTER YOUR DEATH
36 BY FILLING OUT THE FORM FOR THAT TOO.

1 YOU CAN FILL OUT PARTS I AND II OF THIS FORM, OR ONLY PART I, OR ONLY
2 PART II. USE THE FORM TO REFLECT YOUR WISHES, THEN SIGN IN FRONT OF TWO
3 WITNESSES (PART III). IF YOUR WISHES CHANGE, MAKE A NEW ADVANCE DIRECTIVE.

4 MAKE SURE YOU GIVE A COPY OF THE COMPLETED FORM TO YOUR HEALTH
5 CARE AGENT, YOUR DOCTOR, AND OTHERS WHO MIGHT NEED IT. KEEP A COPY AT
6 HOME IN A PLACE WHERE SOMEONE CAN GET IT IF NEEDED. REVIEW WHAT YOU
7 HAVE WRITTEN PERIODICALLY.

8 **PART I: SELECTION OF HEALTH CARE AGENT**

9 A. SELECTION OF PRIMARY AGENT

10 I SELECT THE FOLLOWING INDIVIDUAL AS MY AGENT TO MAKE HEALTH CARE
11 DECISIONS FOR ME:

12 NAME: ____

13 ADDRESS: ____

14 ____

15 TELEPHONE NUMBERS: ______________________________

16 (HOME AND CELL)
17 B. SELECTION OF BACK-UP AGENTS
18 (OPTIONAL; FORM VALID IF LEFT BLANK)

19 1. IF MY PRIMARY AGENT CANNOT BE CONTACTED IN TIME OR FOR ANY
20 REASON IS UNAVAILABLE OR UNABLE OR UNWILLING TO ACT AS MY AGENT,
21 THEN I SELECT THE FOLLOWING PERSON TO ACT IN THIS CAPACITY:

22 NAME: ____

23 ADDRESS: ____

24 ____

25 TELEPHONE NUMBERS: ______________________________

26 (HOME AND CELL)
27 2. IF MY PRIMARY AGENT AND MY FIRST BACK-UP AGENT CANNOT BE
28 CONTACTED IN TIME OR FOR ANY REASON ARE UNAVAILABLE OR UNABLE
29 OR UNWILLING TO ACT AS MY AGENT, THEN I SELECT THE FOLLOWING
30 PERSON TO ACT IN THIS CAPACITY:

31 NAME: ____

32 ADDRESS: ____

33 ____

34 TELEPHONE NUMBERS: ____

1 (HOME AND CELL)
2 C. POWERS AND RIGHTS OF HEALTH CARE AGENT

3 I WANT MY AGENT TO HAVE FULL POWER TO MAKE HEALTH CARE DECISIONS
4 FOR ME, INCLUDING THE POWER TO:

5 1. CONSENT OR NOT CONSENT TO MEDICAL PROCEDURES AND TREATMENTS
6 WHICH MY DOCTORS OFFER, INCLUDING THINGS THAT ARE INTENDED TO
7 KEEP ME ALIVE, LIKE VENTILATORS AND FEEDING TUBES;

8 2. DECIDE WHO MY DOCTOR AND OTHER HEALTH CARE PROVIDERS SHOULD
9 BE; AND

10 3. DECIDE WHERE I SHOULD BE TREATED, INCLUDING WHETHER I SHOULD BE
11 IN A HOSPITAL, NURSING HOME, OTHER MEDICAL CARE FACILITY, OR
12 HOSPICE PROGRAM.

13 I ALSO WANT MY AGENT TO:

14 1. RIDE WITH ME IN AN AMBULANCE IF EVER I NEED TO BE RUSHED TO
15 THE HOSPITAL; AND

16 2. BE ABLE TO VISIT ME IF I AM IN A HOSPITAL OR ANY OTHER HEALTH
17 CARE FACILITY.

18 **THIS ADVANCE DIRECTIVE DOES NOT MAKE MY AGENT RESPONSIBLE FOR**
19 **ANY OF THE COSTS OF MY CARE.**

20 THIS POWER IS SUBJECT TO THE FOLLOWING CONDITIONS OR LIMITATIONS:

21 (OPTIONAL; FORM VALID IF LEFT BLANK)

22 ____

23 ____

24 ____

25 ____

26 ____

27 D. HOW MY AGENT IS TO DECIDE SPECIFIC ISSUES

28 I TRUST MY AGENT'S JUDGMENT. MY AGENT SHOULD LOOK FIRST TO SEE IF THERE
29 IS ANYTHING IN PART II OF THIS ADVANCE DIRECTIVE THAT HELPS DECIDE THE
30 ISSUE. THEN, MY AGENT SHOULD THINK ABOUT THE CONVERSATIONS WE HAVE
31 HAD, MY RELIGIOUS OR OTHER BELIEFS AND VALUES, MY PERSONALITY, AND HOW I
32 HANDLED MEDICAL AND OTHER IMPORTANT ISSUES IN THE PAST. IF WHAT I WOULD
33 DECIDE IS STILL UNCLEAR, THEN MY AGENT IS TO MAKE DECISIONS FOR ME THAT
34 MY AGENT BELIEVES ARE IN MY BEST INTEREST. IN DOING SO, MY AGENT SHOULD
35 CONSIDER THE BENEFITS, BURDENS, AND RISKS OF THE CHOICES PRESENTED BY
36 MY DOCTORS.

1 E. PEOPLE MY AGENT SHOULD CONSULT
2 (OPTIONAL; FORM VALID IF LEFT BLANK)

3 IN MAKING IMPORTANT DECISIONS ON MY BEHALF, I ENCOURAGE MY AGENT TO
4 CONSULT WITH THE FOLLOWING PEOPLE. BY FILLING THIS IN, I DO NOT INTEND TO
5 LIMIT THE NUMBER OF PEOPLE WITH WHOM MY AGENT MIGHT WANT TO CONSULT
6 OR MY AGENT'S POWER TO MAKE THESE DECISIONS.

7 NAME(S) TELEPHONE NUMBER(S)

8 ____________________ _________________________

9 ____________________ _________________________

10 ____________________ _________________________

11 ____________________ _________________________

12 ____________________ _________________________

13 ____________________ _________________________

14 F. IN CASE OF PREGNANCY
15 (OPTIONAL, FOR WOMEN OF CHILD-BEARING YEARS ONLY; FORM VALID IF
16 LEFT BLANK)

17 IF I AM PREGNANT, MY AGENT SHALL FOLLOW THESE SPECIFIC INSTRUCTIONS:

18 ____

19 ____

20 ____

21 G. ACCESS TO MY HEALTH INFORMATION - FEDERAL PRIVACY LAW (HIPAA)
22 AUTHORIZATION

23 1. IF, PRIOR TO THE TIME THE PERSON SELECTED AS MY AGENT HAS POWER
24 TO ACT UNDER THIS DOCUMENT, MY DOCTOR WANTS TO DISCUSS WITH
25 THAT PERSON MY CAPACITY TO MAKE MY OWN HEALTH CARE DECISIONS,
26 I AUTHORIZE MY DOCTOR TO DISCLOSE PROTECTED HEALTH
27 INFORMATION WHICH RELATES TO THAT ISSUE.

28 2. ONCE MY AGENT HAS FULL POWER TO ACT UNDER THIS DOCUMENT, MY
29 AGENT MAY REQUEST, RECEIVE, AND REVIEW ANY INFORMATION, ORAL
30 OR WRITTEN, REGARDING MY PHYSICAL OR MENTAL HEALTH, INCLUDING,
31 BUT NOT LIMITED TO, MEDICAL AND HOSPITAL RECORDS AND OTHER
32 PROTECTED HEALTH INFORMATION, AND CONSENT TO DISCLOSURE OF
33 THIS INFORMATION.

34 3. FOR ALL PURPOSES RELATED TO THIS DOCUMENT, MY AGENT IS MY
35 PERSONAL REPRESENTATIVE UNDER THE HEALTH INSURANCE
36 PORTABILITY AND ACCOUNTABILITY ACT (HIPAA). MY AGENT MAY SIGN, AS
37 MY PERSONAL REPRESENTATIVE, ANY RELEASE FORMS OR OTHER
38 HIPAA-RELATED MATERIALS.

39 H. EFFECTIVENESS OF THIS PART

1 (READ BOTH OF THESE STATEMENTS CAREFULLY. THEN, INITIAL ONE ONLY.)

2 MY AGENT'S POWER IS IN EFFECT:

3 1. IMMEDIATELY AFTER I SIGN THIS DOCUMENT, SUBJECT TO MY RIGHT TO
4 MAKE ANY DECISION ABOUT MY HEALTH CARE IF I WANT AND AM ABLE TO.

5 __________

6 ((OR))

7 2. WHENEVER I AM NOT ABLE TO MAKE INFORMED DECISIONS ABOUT MY
8 HEALTH CARE, EITHER BECAUSE THE DOCTOR IN CHARGE OF MY CARE
9 (ATTENDING PHYSICIAN) DECIDES THAT I HAVE LOST THIS ABILITY
10 **TEMPORARILY**, OR MY ATTENDING PHYSICIAN AND A CONSULTING
11 DOCTOR AGREE THAT I HAVE LOST THIS ABILITY **PERMANENTLY**.

12 __________

13 IF THE ONLY THING YOU WANT TO DO IS SELECT A HEALTH CARE AGENT, SKIP
14 PART II. GO TO PART III TO SIGN AND HAVE THE ADVANCE DIRECTIVE
15 WITNESSED. IF YOU ALSO WANT TO WRITE YOUR TREATMENT PREFERENCES,
16 USE PART II. ALSO CONSIDER BECOMING AN ORGAN DONOR, USING THE
17 SEPARATE FORM FOR THAT.

18 **PART II: TREATMENT PREFERENCES ("LIVING WILL")**

19 A. STATEMENT OF GOALS AND VALUES
20 (OPTIONAL; FORM VALID IF LEFT BLANK)

21 I WANT TO SAY SOMETHING ABOUT MY GOALS AND VALUES, AND ESPECIALLY
22 WHAT'S MOST IMPORTANT TO ME DURING THE LAST PART OF MY LIFE:

23 ____

24 ____
25 ____
26 ____
27 ____
28 ____

29 B. PREFERENCE IN CASE OF TERMINAL CONDITION

30 (IF YOU WANT TO STATE YOUR PREFERENCE, INITIAL ONE ONLY. IF YOU DO
31 NOT WANT TO STATE A PREFERENCE HERE, CROSS THROUGH THE WHOLE
32 SECTION.)

33 **IF MY DOCTORS CERTIFY THAT MY DEATH FROM A TERMINAL CONDITION**
34 **IS IMMINENT, EVEN IF LIFE-SUSTAINING PROCEDURES ARE USED:**

35 1. KEEP ME COMFORTABLE AND ALLOW NATURAL DEATH TO OCCUR. I DO
36 NOT WANT ANY MEDICAL INTERVENTIONS USED TO TRY TO EXTEND MY

1 LIFE. I DO NOT WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR
2 OTHER MEDICAL MEANS.

3 __________

4 ((OR))

5 2. KEEP ME COMFORTABLE AND ALLOW NATURAL DEATH TO OCCUR. I DO
6 NOT WANT MEDICAL INTERVENTIONS USED TO TRY TO EXTEND MY LIFE.
7 IF I AM UNABLE TO TAKE ENOUGH NOURISHMENT BY MOUTH, HOWEVER, I
8 WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR OTHER MEDICAL
9 MEANS.

10 __________

11 ((OR))

12 3. TRY TO EXTEND MY LIFE FOR AS LONG AS POSSIBLE, USING ALL
13 AVAILABLE INTERVENTIONS ~~IN ACCORDANCE WITH ACCEPTED MEDICAL~~
14 ~~STANDARDS~~ THAT IN REASONABLE MEDICAL JUDGMENT WOULD PREVENT
15 OR DELAY MY DEATH. IF I AM UNABLE TO TAKE ENOUGH NOURISHMENT
16 BY MOUTH, I WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR
17 OTHER MEDICAL MEANS.

18 __________

19 C. PREFERENCE IN CASE OF PERSISTENT VEGETATIVE STATE

20 (IF YOU WANT TO STATE YOUR PREFERENCE, INITIAL ONE ONLY. IF YOU DO
21 NOT WANT TO STATE A PREFERENCE HERE, CROSS THROUGH THE WHOLE
22 SECTION.)

23 **IF MY DOCTORS CERTIFY THAT I AM IN A PERSISTENT VEGETATIVE STATE,**
24 **THAT IS, IF I AM NOT CONSCIOUS AND AM NOT AWARE OF MYSELF OR MY**
25 **ENVIRONMENT OR ABLE TO INTERACT WITH OTHERS, AND THERE IS NO**
26 **REASONABLE EXPECTATION THAT I WILL EVER REGAIN CONSCIOUSNESS:**

27 1. KEEP ME COMFORTABLE AND ALLOW NATURAL DEATH TO OCCUR. I DO
28 NOT WANT ANY MEDICAL INTERVENTIONS USED TO TRY TO EXTEND MY
29 LIFE. I DO NOT WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR
30 OTHER MEDICAL MEANS.

31 __________

32 ((OR))

33 2. KEEP ME COMFORTABLE AND ALLOW NATURAL DEATH TO OCCUR. I DO
34 NOT WANT MEDICAL INTERVENTIONS USED TO TRY TO EXTEND MY LIFE.
35 IF I AM UNABLE TO TAKE ENOUGH NOURISHMENT BY MOUTH, HOWEVER, I
36 WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR OTHER MEDICAL

1 MEANS.

2 __________

3 ((OR))

4 3. TRY TO EXTEND MY LIFE FOR AS LONG AS POSSIBLE, USING ALL
5 AVAILABLE INTERVENTIONS ~~IN ACCORDANCE WITH ACCEPTED MEDICAL~~
6 ~~STANDARDS~~ THAT IN REASONABLE MEDICAL JUDGMENT WOULD PREVENT
7 OR DELAY MY DEATH. IF I AM UNABLE TO TAKE ENOUGH NOURISHMENT
8 BY MOUTH, I WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR
9 OTHER MEDICAL MEANS.

10 __________

11 D. PREFERENCE IN CASE OF END-STAGE CONDITION

12 (IF YOU WANT TO STATE YOUR PREFERENCE, INITIAL ONE ONLY. IF YOU DO
13 NOT WANT TO STATE A PREFERENCE HERE, CROSS THROUGH THE WHOLE
14 SECTION.)

15 **IF MY DOCTORS CERTIFY THAT I AM IN AN END-STAGE CONDITION, THAT**
16 **IS, AN INCURABLE CONDITION THAT WILL ~~KEEP GETTING WORSE~~**
17 **CONTINUE IN ITS COURSE UNTIL DEATH AND THAT HAS ALREADY**
18 **RESULTED IN LOSS OF CAPACITY AND COMPLETE PHYSICAL**
19 **DEPENDENCY:**

20 1. KEEP ME COMFORTABLE AND ALLOW NATURAL DEATH TO OCCUR. I DO
21 NOT WANT ANY MEDICAL INTERVENTIONS USED TO TRY TO EXTEND MY
22 LIFE. I DO NOT WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR
23 OTHER MEDICAL MEANS.

24 __________

25 ((OR))

26 2. KEEP ME COMFORTABLE AND ALLOW NATURAL DEATH TO OCCUR. I DO
27 NOT WANT MEDICAL INTERVENTIONS USED TO TRY TO EXTEND MY LIFE.
28 IF I AM UNABLE TO TAKE ENOUGH NOURISHMENT BY MOUTH, HOWEVER, I
29 WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR OTHER MEDICAL
30 MEANS.

31 __________

32 ((OR))

33 3. TRY TO EXTEND MY LIFE FOR AS LONG AS POSSIBLE, USING ALL
34 AVAILABLE INTERVENTIONS ~~IN ACCORDANCE WITH ACCEPTED MEDICAL~~
35 ~~STANDARDS~~ THAT IN REASONABLE MEDICAL JUDGMENT WOULD PREVENT
36 OR DELAY MY DEATH. IF I AM UNABLE TO TAKE ENOUGH NOURISHMENT
37 BY MOUTH, I WANT TO RECEIVE NUTRITION AND FLUIDS BY TUBE OR

1 OTHER MEDICAL MEANS.

2 __________

3 E. PAIN RELIEF

4 NO MATTER WHAT MY CONDITION, GIVE ME THE MEDICINE OR OTHER
5 TREATMENT I NEED TO RELIEVE PAIN.

6 __________

7 F. IN CASE OF PREGNANCY

8 (OPTIONAL, FOR WOMEN OF CHILD-BEARING YEARS ONLY; FORM VALID IF
9 LEFT BLANK)

10 IF I AM PREGNANT, MY DECISION CONCERNING LIFE-SUSTAINING
11 PROCEDURES SHALL BE MODIFIED AS FOLLOWS:

12 ____

13 ____
14 ____
15 ____

16 G. EFFECT OF STATED PREFERENCES

17 (READ BOTH OF THESE STATEMENTS CAREFULLY. THEN, INITIAL ONE ONLY.)

18 1. I REALIZE I CANNOT FORESEE EVERYTHING THAT MIGHT HAPPEN AFTER I
19 CAN NO LONGER DECIDE FOR MYSELF. MY STATED PREFERENCES ARE
20 MEANT TO GUIDE WHOEVER IS MAKING DECISIONS ON MY BEHALF AND
21 MY HEALTH CARE PROVIDERS, BUT I AUTHORIZE THEM TO BE FLEXIBLE IN
22 APPLYING THESE STATEMENTS IF THEY FEEL THAT DOING SO WOULD BE
23 IN MY BEST INTEREST.

24 __________

25 ((OR))

26 2. I REALIZE I CANNOT FORESEE EVERYTHING THAT MIGHT HAPPEN AFTER I
27 CAN NO LONGER DECIDE FOR MYSELF. STILL, I WANT WHOEVER IS
28 MAKING DECISIONS ON MY BEHALF AND MY HEALTH CARE PROVIDERS TO
29 FOLLOW MY STATED PREFERENCES EXACTLY AS WRITTEN, EVEN IF THEY
30 THINK THAT SOME ALTERNATIVE IS BETTER.

31 __________

32 **PART III: SIGNATURE AND WITNESSES**

33 BY SIGNING BELOW AS THE DECLARANT, I INDICATE THAT I AM EMOTIONALLY AND
34 MENTALLY COMPETENT TO MAKE THIS ADVANCE DIRECTIVE AND THAT I
35 UNDERSTAND ITS PURPOSE AND EFFECT. I ALSO UNDERSTAND THAT THIS

1 DOCUMENT REPLACES ANY SIMILAR ADVANCE DIRECTIVE I MAY HAVE COMPLETED
2 BEFORE THIS DATE.

3 ______________________________ ____________________
4 (SIGNATURE OF DECLARANT) (DATE)

5 THE DECLARANT SIGNED OR ACKNOWLEDGED SIGNING THIS DOCUMENT IN MY
6 PRESENCE AND, BASED UPON PERSONAL OBSERVATION, APPEARS TO BE
7 EMOTIONALLY AND MENTALLY COMPETENT TO MAKE THIS ADVANCE DIRECTIVE.

8 ______________________________ ____________________
9 (SIGNATURE OF WITNESS) (DATE)

10 ______________________________
11 TELEPHONE NUMBER(S)

12 ______________________________ ____________________
13 (SIGNATURE OF WITNESS) (DATE)

14 ______________________________
15 TELEPHONE NUMBER(S)

16 (NOTE: ANYONE SELECTED AS A HEALTH CARE AGENT IN PART I MAY NOT BE A
17 WITNESS. ALSO, AT LEAST ONE OF THE WITNESSES MUST BE SOMEONE WHO WILL
18 NOT KNOWINGLY INHERIT ANYTHING FROM THE DECLARANT OR OTHERWISE
19 KNOWINGLY GAIN A FINANCIAL BENEFIT FROM THE DECLARANT'S DEATH.
20 MARYLAND LAW DOES **NOT** REQUIRE THIS DOCUMENT TO BE NOTARIZED.)

21 **AFTER MY DEATH~~: DONATION OF ORGANS OR BODY~~**
22 (THIS FORM IS OPTIONAL. FILL OUT ONLY WHAT REFLECTS YOUR WISHES.)

23 BY:______________________________ DATE OF BIRTH: ____________________
24 (PRINT NAME) (MONTH/DAY/YEAR)

25 **PART I: ORGAN DONATION**

26 (INITIAL THE ONES THAT YOU WANT.)

27 UPON MY DEATH I WISH TO DONATE:

28 ANY NEEDED ORGANS, TISSUES, OR EYES. __________

29 ONLY THE FOLLOWING ORGANS, TISSUES, OR EYES: __________

30 ____
31 ____
32 ____
33 ____

1 I AUTHORIZE THE USE OF MY ORGANS, TISSUES, OR EYES:

2 FOR TRANSPLANTATION __________

3 FOR THERAPY __________

4 FOR RESEARCH __________

5 FOR MEDICAL EDUCATION __________

6 FOR ANY PURPOSE AUTHORIZED BY LAW __________

7 I UNDERSTAND THAT NO VITAL ORGAN, TISSUE, OR EYE MAY BE REMOVED
8 FOR TRANSPLANTATION UNTIL AFTER I HAVE BEEN PRONOUNCED DEAD
9 UNDER LEGAL STANDARDS. **THIS DOCUMENT IS NOT INTENDED TO CHANGE**
10 **ANYTHING ABOUT MY HEALTH CARE WHILE I AM STILL ALIVE**. AFTER
11 DEATH, I AUTHORIZE ANY APPROPRIATE SUPPORT MEASURES TO MAINTAIN
12 THE VIABILITY FOR TRANSPLANTATION OF MY ORGANS, TISSUES, AND EYES
13 UNTIL ORGAN, TISSUE, AND EYE RECOVERY HAS BEEN COMPLETED. I
14 UNDERSTAND THAT MY ESTATE WILL NOT BE CHARGED FOR ANY COSTS
15 RELATED TO THIS DONATION.

16 **PART II: DONATION OF BODY**

17 AFTER ANY ORGAN DONATION INDICATED IN PART I, I WISH MY BODY TO BE
18 DONATED FOR USE IN A MEDICAL STUDY PROGRAM.

19 . ________________________

20 **PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS**

21 I WANT THE FOLLOWING PERSON TO MAKE DECISIONS ABOUT THE DISPOSITION OF
22 MY BODY AND MY FUNERAL ARRANGEMENTS:

23 (EITHER INITIAL THE FIRST OR FILL IN THE SECOND.)

24 THE HEALTH CARE AGENT WHO I NAMED IN MY ADVANCE DIRECTIVE.

25 __________

26 ((OR))

27 THIS PERSON:

28 NAME:____

29 ADDRESS:____
30 ____
31 ____

32 TELEPHONE NUMBERS:____

1 (HOME AND CELL)

2 IF I HAVE WRITTEN MY WISHES BELOW, THEY SHOULD BE FOLLOWED. IF NOT, THE
3 PERSON I HAVE NAMED SHOULD DECIDE BASED ON CONVERSATIONS WE HAVE HAD,
4 MY RELIGIOUS OR OTHER BELIEFS AND VALUES, MY PERSONALITY, AND HOW I
5 REACTED TO OTHER PEOPLES' FUNERAL ARRANGEMENTS. MY WISHES ABOUT THE
6 DISPOSITION OF MY BODY AND MY FUNERAL ARRANGEMENTS ARE:

7 ______________________________

8 ______________________________

9 ______________________________

10 ______________________________
11 ______________________________

12 **PART ~~III~~ IV: SIGNATURE AND WITNESSES**

13 BY SIGNING BELOW, I INDICATE THAT I AM EMOTIONALLY AND MENTALLY
14 COMPETENT TO MAKE THIS DONATION AND THAT I UNDERSTAND THE PURPOSE AND
15 EFFECT OF THIS DOCUMENT.

16 ______________________ ______________
17 (SIGNATURE OF DONOR) (DATE)

18 THE DONOR SIGNED OR ACKNOWLEDGED SIGNING THIS DONATION DOCUMENT IN
19 MY PRESENCE AND, BASED UPON PERSONAL OBSERVATION, APPEARS TO BE
20 EMOTIONALLY AND MENTALLY COMPETENT TO MAKE THIS DONATION.

21 ______________________ ______________
22 (SIGNATURE OF DONOR) (DATE)

23 ______________________
24 TELEPHONE NUMBER(S)

25 ______________________ ______________
26 (SIGNATURE OF WITNESS) (DATE)

27 ______________________
28 TELEPHONE NUMBER(S)

29 5-605.

30 (a) (1) In this subsection, "unavailable" means:

31 (i) After reasonable inquiry, a health care provider is unaware of
32 the existence of a HEALTH CARE AGENT OR surrogate decision maker;

33 (ii) After reasonable inquiry, a health care provider cannot
34 ascertain the whereabouts of a HEALTH CARE AGENT OR surrogate decision maker;

(iii) A HEALTH CARE AGENT OR surrogate decision maker has not responded in a timely manner, taking into account the health care needs of the individual, to a written or oral message from a health care provider;

(iv) A HEALTH CARE AGENT OR surrogate decision maker is incapacitated; or

(v) A HEALTH CARE AGENT OR surrogate decision maker is unwilling to make decisions concerning health care for the individual.

(2) The following individuals or groups, in the specified order of priority, may make decisions about health care for a person who has been certified to be incapable of making an informed decision and who has not appointed a health care agent in accordance with this subtitle OR WHOSE HEALTH CARE AGENT IS UNAVAILABLE. Individuals in a particular class may be consulted to make a decision only if all individuals in the next higher class are unavailable:

(i) A guardian for the patient, if one has been appointed;

(ii) The patient's spouse;

(iii) An adult child of the patient;

(iv) A parent of the patient;

(v) An adult brother or sister of the patient; or

(vi) A friend or other relative of the patient who meets the requirements of paragraph (3) of this subsection.

~~5-606.~~

~~(a) (1) Prior to providing, withholding, or withdrawing treatment for which authorization has been obtained or will be sought under this subtitle, the attending physician and a second physician OR A LICENSED PSYCHOLOGIST~~ NURSE PRACTITIONER~~, one of whom shall have examined the patient within 2 hours before making the certification, shall certify in writing that the patient is incapable of making an informed decision regarding the treatment. The certification shall be based on a personal examination of the patient.~~

~~(2) If a patient is unconscious, or unable to communicate by any means, the certification of a second physician OR A LICENSED PSYCHOLOGIST~~ NURSE PRACTITIONER ~~is not required under paragraph (1) of this subsection.~~

~~(3) When authorization is sought for treatment of a mental illness, the second physician OR LICENSED PSYCHOLOGIST~~ NURSE PRACTITIONER ~~may not be otherwise currently involved in the treatment of the person assessed.~~

~~(4) The cost of an assessment to certify incapacity under this subsection shall be considered for all purposes a cost of the patient's treatment.~~

1 SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect
2 October 1, 2006.