J1 6lr2183
CF 6lr2624

By: **Senator Hollinger**
Introduced and read first time: January 30, 2006
Assigned to: Education, Health, and Environmental Affairs

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 8, 2006

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; and
10 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)

16 BY adding to
17 Article - Health - General
18 Section 5-603
19 Annotated Code of Maryland
20 (2005 Replacement Volume and 2005 Supplement)

21 BY repealing and reenacting, with amendments,
22 Article - Health - General
23 Section 5-605(a)(1) and (2) and 5-606(a)

1 Annotated Code of Maryland
2 (2005 Replacement Volume and 2005 Supplement)

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5 Code of Maryland be repealed.

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

8 **Article - Health - General**

9 5-603.

10 MARYLAND ADVANCE DIRECTIVE:
11 PLANNING FOR FUTURE HEALTH CARE DECISIONS

12 BY: __________________________ DATE OF BIRTH: ____________________
13 (PRINT NAME) (MONTH/DAY/YEAR)

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

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

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

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

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

37 A. SELECTION OF PRIMARY AGENT

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

3 NAME: ____

4 ADDRESS: ____

5 ____

6 TELEPHONE NUMBERS: ___________________________________

7 (HOME AND CELL)
8 B. SELECTION OF BACK-UP AGENTS
9 (OPTIONAL; FORM VALID IF LEFT BLANK)

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

13 NAME: ____

14 ADDRESS: ____

15 ____

16 TELEPHONE NUMBERS: ___________________________________

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

22 NAME: ____

23 ADDRESS: ____

24 ____

25 TELEPHONE NUMBERS: ___________________________________

26 (HOME AND CELL)
27 C. POWERS <u>AND RIGHTS</u> OF HEALTH CARE AGENT

28 I WANT MY AGENT TO HAVE FULL POWER TO MAKE HEALTH CARE DECISIONS

29 FOR ME, INCLUDING THE POWER TO:

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

33 2. DECIDE WHO MY DOCTOR AND OTHER HEALTH CARE PROVIDERS SHOULD
34 BE; AND

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

4 I ALSO WANT MY AGENT TO:

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

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

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

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

12 (OPTIONAL; FORM VALID IF LEFT BLANK)

13 ____

14 ____

15 ____

16 ____

17 ____

18 D. HOW MY AGENT IS TO DECIDE SPECIFIC ISSUES

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

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

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

34 NAME(S) TELEPHONE NUMBER(S)

35 ____________________ ________________________

36 ____________________ ________________________

37 ____________________ ________________________
38 ____________________ ________________________

1 ____________________ _________________________

2 ____________________ _________________________

3 F. IN CASE OF PREGNANCY
4 (OPTIONAL, FOR WOMEN OF CHILD-BEARING YEARS ONLY; FORM VALID IF
5 LEFT BLANK)

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

7 ____

8 ____

9 ____

10 G. ACCESS TO MY HEALTH INFORMATION - FEDERAL PRIVACY LAW (HIPAA)
11 AUTHORIZATION

12 1. IF, PRIOR TO THE TIME THE PERSON SELECTED AS MY AGENT HAS POWER
13 TO ACT UNDER THIS DOCUMENT, MY DOCTOR WANTS TO DISCUSS WITH
14 THAT PERSON MY CAPACITY TO MAKE MY OWN HEALTH CARE DECISIONS,
15 I AUTHORIZE MY DOCTOR TO DISCLOSE PROTECTED HEALTH
16 INFORMATION WHICH RELATES TO THAT ISSUE.

17 2. ONCE MY AGENT HAS FULL POWER TO ACT UNDER THIS DOCUMENT, MY
18 AGENT MAY REQUEST, RECEIVE, AND REVIEW ANY INFORMATION, ORAL
19 OR WRITTEN, REGARDING MY PHYSICAL OR MENTAL HEALTH, INCLUDING,
20 BUT NOT LIMITED TO, MEDICAL AND HOSPITAL RECORDS AND OTHER
21 PROTECTED HEALTH INFORMATION, AND CONSENT TO DISCLOSURE OF
22 THIS INFORMATION.

23 3. FOR ALL PURPOSES RELATED TO THIS DOCUMENT, MY AGENT IS MY
24 PERSONAL REPRESENTATIVE UNDER THE HEALTH INSURANCE
25 PORTABILITY AND ACCOUNTABILITY ACT (HIPAA). MY AGENT MAY SIGN, AS
26 MY PERSONAL REPRESENTATIVE, ANY RELEASE FORMS OR OTHER
27 HIPAA-RELATED MATERIALS.

28 H. EFFECTIVENESS OF THIS PART
29 (READ BOTH OF THESE STATEMENTS CAREFULLY. THEN, INITIAL ONE ONLY.)

30 MY AGENT'S POWER IS IN EFFECT:

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

33 __________

34 ((OR))

35 2. WHENEVER I AM NOT ABLE TO MAKE INFORMED DECISIONS ABOUT MY
36 HEALTH CARE, EITHER BECAUSE THE DOCTOR IN CHARGE OF MY CARE
37 (ATTENDING PHYSICIAN) DECIDES THAT I HAVE LOST THIS ABILITY

1 **TEMPORARILY**, OR MY ATTENDING PHYSICIAN AND A CONSULTING
2 DOCTOR AGREE THAT I HAVE LOST THIS ABILITY **PERMANENTLY**.

3 __________

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

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

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

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

14 ____

15 ____
16 ____
17 ____
18 ____
19 ____

20 B. PREFERENCE IN CASE OF TERMINAL CONDITION

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

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

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

30 __________

31 ((OR))

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

37 __________

((OR))

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

____

C. PREFERENCE IN CASE OF PERSISTENT VEGETATIVE STATE

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

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

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

____

((OR))

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

____

((OR))

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

____

D. PREFERENCE IN CASE OF END-STAGE CONDITION

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

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

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

____

((OR))

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

____

((OR))

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

____

E. PAIN RELIEF

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

____

F. IN CASE OF PREGNANCY

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

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

3 ____

4 ____
5 ____
6 ____

7 G. EFFECT OF STATED PREFERENCES

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

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

15 __________

16 ((OR))

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

22 __________

23 **PART III: SIGNATURE AND WITNESSES**

24 BY SIGNING BELOW AS THE DECLARANT, I INDICATE THAT I AM EMOTIONALLY AND
25 MENTALLY COMPETENT TO MAKE THIS ADVANCE DIRECTIVE AND THAT I
26 UNDERSTAND ITS PURPOSE AND EFFECT. I ALSO UNDERSTAND THAT THIS
27 DOCUMENT REPLACES ANY SIMILAR ADVANCE DIRECTIVE I MAY HAVE COMPLETED
28 BEFORE THIS DATE.

29 ________________________________ ____________________
30 (SIGNATURE OF DECLARANT) (DATE)

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

34 ________________________________ ____________________
35 (SIGNATURE OF WITNESS) (DATE)

36 ________________________________
37 TELEPHONE NUMBER(S)

1 ________________________________ ____________________
2 (SIGNATURE OF WITNESS) (DATE)

3 ________________________________
4 TELEPHONE NUMBER(S)

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

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

12 BY:______________________________ DATE OF BIRTH: ____________________
13 (PRINT NAME) (MONTH/DAY/YEAR)

14 **PART I: ORGAN DONATION**

15 (INITIAL THE ONES THAT YOU WANT.)

16 UPON MY DEATH I WISH TO DONATE:

17 ANY NEEDED ORGANS, TISSUES, OR EYES. __________

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

19 ____
20 ____
21 ____
22 ____

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

24 FOR TRANSPLANTATION __________

25 FOR THERAPY __________

26 FOR RESEARCH __________

27 FOR MEDICAL EDUCATION __________

28 FOR ANY PURPOSE AUTHORIZED BY LAW __________

29 I UNDERSTAND THAT NO VITAL ORGAN, TISSUE, OR EYE MAY BE REMOVED
30 FOR TRANSPLANTATION UNTIL AFTER I HAVE BEEN PRONOUNCED DEAD
31 UNDER LEGAL STANDARDS. **THIS DOCUMENT IS NOT INTENDED TO CHANGE**
32 **ANYTHING ABOUT MY HEALTH CARE WHILE I AM STILL ALIVE**. AFTER

1 DEATH, I AUTHORIZE ANY APPROPRIATE SUPPORT MEASURES TO MAINTAIN
2 THE VIABILITY FOR TRANSPLANTATION OF MY ORGANS, TISSUES, AND EYES
3 UNTIL ORGAN, TISSUE, AND EYE RECOVERY HAS BEEN COMPLETED. I
4 UNDERSTAND THAT MY ESTATE WILL NOT BE CHARGED FOR ANY COSTS
5 RELATED TO THIS DONATION.

6 **PART II: DONATION OF BODY**

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

9 . ______________________

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

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

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

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

15 __________

16 ((OR))

17 THIS PERSON:

18 NAME:____

19 ADDRESS:____
20 ____
21 ____

22 TELEPHONE NUMBERS:____
23 (HOME AND CELL)

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

29
____
____
30
____
____
31
____
____
32 ____
33 ____

PART ~~III~~ IV: SIGNATURE AND WITNESSES

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

______________________________ __________________
(SIGNATURE OF DONOR) (DATE)

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

______________________________ __________________
(SIGNATURE OF DONOR) (DATE)

____
TELEPHONE NUMBER(S)

______________________________ __________________
(SIGNATURE OF WITNESS) (DATE)

____
TELEPHONE NUMBER(S)

5-605.

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

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

(ii) After reasonable inquiry, a health care provider cannot 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:

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

2 (ii) The patient's spouse;

3 (iii) An adult child of the patient;

4 (iv) A parent of the patient;

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

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

8 5-606.

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

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

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

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

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