Commonwealth Healthcare Corporation

Commonwealth of the Northern Mariana Islands
1 Lower Navy Hill Road Navy Hill, Saipan, MP 96950

COMMONWEALTH HEALTH CENTER

ADVANCE DIRECTIVE – LIVING WILL

***You have the right to give instructions about your own health care and this form lets you express, in advance your wishes in the event you cannot speak for yourself.*

Patient Name: _____ Medical Record No.: _____

DECLARATION IF I AM IN A TERMINAL CONDITION AND UNABLE TO MAKE MY OWN HEALTH CARE DECISIONS:

If I should have an incurable or irreversible condition, that has been diagnosed by my physician and at least another health care provider, **that will result in my death within a relatively short time without the administration of life-sustaining treatment, AND I am no longer able to make decisions regarding my medical treatment**, I hereby direct my attending physician, pursuant to the Medical Consent Act of the Commonwealth of the Northern Mariana Islands, to withhold or withdraw life-sustaining treatment that only prolongs the process of dying or the irreversible coma or persistent vegetative state and is not necessary for my comfort, nutrition, hydration or to alleviate pain.

Place your initials in the box if you AGREE with the above Declaration: ☐

DECLARATION IF I AM IN A PERMANENTLY UNCONSCIOUS STATE:

If I am in a permanently unconscious state or if I should have an incurable or irreversible condition, that has been diagnosed by my physician and at least another health care provider, **that has produced an irreversible coma or persistent vegetative state, AND I am no longer able to make decisions regarding my medical treatment**, I hereby direct my attending physician, pursuant to the Medical Consent Act of the Commonwealth of the Northern Mariana Islands, to withhold or withdraw life-sustaining treatment that only prolongs the process of dying or the irreversible coma or persistent vegetative state and is not necessary for my comfort, nutrition, hydration or to alleviate pain.

Place your initials in the box if you AGREE with the above Declaration: ☐

I hereby declare that this Living Will was voluntarily prepared by me and that I have independently made the choices specified above on my own after significant thought and consideration.

_____ _____
Signature *Date*

Additional Instructions:

_____

_____

_____

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_____

WITNESSES

[This Living Will Declaration will not be valid unless it is either signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature, or it is acknowledged before a Notary Public]

The declarant voluntarily signed this document in my presence. I am not entitled to any portion of the estate of the declarant upon his or her death under any will or codicil thereto of the declarant now existing or by operation of law. I am not a health care provider, an employee of a health care provider, the operator of a community care family, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, or an employee of an operator of a residential care facility for the elderly.

Witness #1: _____ residing at _____
(Print Name) *(Village)*

Signature: _____ Date: _____

Witness #2: _____ residing at _____
(Print Name) *(Village)*

Signature: _____ Date: _____

NOTARIZATION