

# MARYLAND Advance Directive Planning for Important Healthcare Decisions

*Caring Connections*  
1731 King St, Suite 100, Alexandria, VA 22314  
[www.caringinfo.org](http://www.caringinfo.org)  
800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

## **It's About How You LIVE**

*It's About How You LIVE* is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

**Note:** The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

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## Using these Materials

### BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
  - Instructions for preparing your advance directive, please read all the instructions.
  - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

### ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.
5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

## INTRODUCTION TO YOUR MARYLAND ADVANCE DIRECTIVE

This packet contains two legal documents, the Maryland Advance Directive that protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself, and the Maryland "After My Death" form, a document that allows you to record your decisions regarding organ donation and the final disposition of your remains.

The Maryland Advance Directive is divided into three parts. You may fill out Part I, Part II, or both, depending on your advance planning needs. You must complete Part III.

**Part I, Selection of Health Care Agent**, lets you name someone (an agent) to make decisions about your health care. This part becomes effective either immediately, or when your doctor determines that you can no longer make or communicate your health care decisions, depending on how you fill out the form.

**Part II** includes your **Treatment Preferences**. This is your state's living will. It lets you state your wishes about health care in the event that you can no longer speak for yourself. Part II has specific choices laid out for you in the event you have a terminal condition, are in a persistent vegetative state (permanent unconsciousness), or develop an end-stage condition. Alternatively, you can provide your own instructions. In addition, the form allows you to choose whether your agent will have flexibility in implementing your decisions or be required to carry out your instructions exactly as you set them out.

Part II becomes effective when your doctor determines that you can no longer make or communicate your health care decisions.

**Part III** contains the signature and witnessing provisions so that your document will be effective.

Following the Maryland Advance Directive is a form, called "After My Death," which allows you to record your organ donation and final remains disposition preferences.

The Maryland Advance Directive form does not expressly address mental illness. If you would like to make advance care plans regarding mental illness, you should talk to your physician and an attorney about a directive tailored to your needs. The Maryland Department of Mental Health and Hygiene provides an advance directive focused on mental-health issues on its webpage at <http://www.dhmh.state.md.us/mha/forms.html>

*Note: This document will be legally binding only if the person completing it is either: (1) 18 years of age or older, or (2) if under the age of 18, is married or is the parent of a child.*

## **INSTRUCTIONS COMPLETING YOUR MARYLAND ADVANCE DIRECTIVE**

### **How do I make my Maryland Advance Directive legal?**

You must sign and date your advance directive in the presence of two witnesses, who must also sign and date the document.

Your agent may not be a witness. In addition, at least one of your witnesses must be someone who will not knowingly inherit anything from your estate or otherwise knowingly benefit from your death.

### **Whom should I appoint as my agent?**

Your agent is the person you appoint to make decisions about your health care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making health care decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

You cannot appoint as your agent:

- An owner, operator, or employee of your treating health care facility; or
- The spouse, parent, child, or sibling of any of the above health care facility-affiliated individuals

However, you may appoint a person who would otherwise be barred from being your agent if that person is your guardian, spouse, domestic partner, adult child, parent, sibling, or other close relative or close friend who could be appointed as your surrogate in the event you do not appoint an agent.

### **Should I add personal instructions to my Appointment of Health Care Agent?**

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your health care situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

### **What if I change my mind?**

If you decide to cancel your Maryland Advance Directive, you may do so at any time by:

- issuing a signed and dated written or electronic revocation,
- destroying or defacing your document,
- orally informing your doctor of your revocation, or
- executing another Maryland Advance Directive.

You should notify your agent, physician, and anyone who has a photocopy of your advance directive that you have revoked it.

**How do I make my “After My Death” form legal?**

You must sign and date your “After My Death” form in the presence of two witnesses, who must also sign and date the document.

**MARYLAND ADVANCE DIRECTIVE**

Planning for Future Health Care Decisions

PRINT YOUR NAME  
AND YOUR DATE OF  
BIRTH

By: \_\_\_\_\_  
(Print Name)

Date of Birth: \_\_\_\_\_  
(Month/Day/Year)

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. Make sure you talk to your health care agent (and any back-up agents) about this important role. Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that too.

You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive.

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

MARYLAND ADVANCE DIRECTIVE – PAGE 2 OF 13

PART I

PART I: SELECTION OF HEALTH CARE AGENT

A. Selection of Primary Agent

I select the following individual as my agent to make health care decisions for me:

Name:

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Numbers: \_\_\_\_\_  
(home and cell)

B. Selection of Back-up Agents

(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name:

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Numbers: \_\_\_\_\_  
(home and cell)

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Numbers: \_\_\_\_\_  
(home and cell)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER(S) OF YOUR PRIMARY AGENT

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER(S) OF YOUR FIRST BACK-UP AGENT

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER(S) OF YOUR SECOND BACK-UP AGENT

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POWERS OF YOUR  
AGENT: CROSS  
OUT ANY POWERS  
YOU DO NOT WANT  
TO GIVE

C. Powers and Rights of Health Care Agent

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not consent to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;
2. Decide who my doctor and other health care providers should be; and
3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.

I also want my agent to:

1. Ride with me in an ambulance if ever I need to be rushed to the hospital; and
2. Be able to visit me if I am in a hospital or any other health care facility.

This advance directive does not make my agent responsible for any of the costs of my care.

This power is subject to the following conditions or limitations:

(Optional; form valid if left blank)

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(Attach additional pages, if needed.)

PRINT  
INSTRUCTIONS  
HERE ONLY IF YOU  
WANT TO LIMIT  
YOUR AGENT'S  
POWERS

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D. How My Agent Is To Decide Specific Issues

I trust my agent's judgment. My agent should look first to see if there is anything in Part II of this advance directive, if I have filled out Part II, that helps decide the issue. Then, my agent should think about the conversations we have had, my religious or other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

E. People My Agent Should Consult

(Optional; form valid if left blank)

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent's power to make these decisions.

Name(s) Telephone Number(s):

Multiple horizontal lines for entering names and telephone numbers.

PRINT THE NAMES AND TELEPHONE NUMBERS OF ANYONE YOU WANT YOUR AGENT TO CONSULT WITH IN MAKING DECISIONS FOR YOU (OPTIONAL)

F. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my agent shall follow these specific instructions:

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(Attach additional pages, if needed.)

G. Access to My Health Information - Federal Privacy Law (HIPAA) Authorization

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.

2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

PRINT ANY  
INSTRUCTIONS IN  
THE EVENT YOU  
ARE PREGNANT  
WHEN A DECISION  
MUST BE MADE

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H. Effectiveness of This Part

(Read both of these statements carefully. Then, initial one only.)

My agent's power is in effect:

\_\_\_\_\_ 1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

**OR**

\_\_\_\_\_ 2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability permanently.

If the only thing you want to do is select a health care agent, skip Part II, and go to Part III to sign and have the advance directive witnessed. If you also want to write your treatment preferences, use Part II. Also consider becoming an organ donor, using the separate "After my Death" form for that.

INITIAL ONLY ONE



**PART II: TREATMENT PREFERENCES (“LIVING WILL”)**

B. Preference in Case of Terminal 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 have a terminal condition, that is, if I have an incurable condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life-sustaining procedures, there can be no recovery:

\_\_\_\_\_ 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 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.

INITIAL YOUR  
PREFERENCE IN  
THE EVENT YOU  
ARE IN A TERMINAL  
CONDITION

INITIAL ONLY ONE  
PREFERENCE

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 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.

INITIAL YOUR  
PREFERENCE IN  
THE EVENT YOU  
ARE IN A  
PERSISTENT  
VEGETATIVE STATE

INITIAL ONLY ONE  
PREFERENCE

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 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 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.

INITIAL YOUR  
PREFERENCE IN  
THE EVENT YOU  
DEVELOP AN END-  
STAGE CONDITION

INITIAL ONLY ONE  
PREFERENCE

**MARYLAND ADVANCE DIRECTIVE – PAGE 11 OF 13**

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E. Additional Instructions:

(You may add additional instructions, if any, here. This section may be useful to you if you have crossed through the sections above, or if your concerns are not otherwise addressed by this form.)

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ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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(Attach additional pages, if needed.)



F. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

G. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Attach additional pages, if needed.)

H. Effect of Stated Preferences

(Read both of these statements carefully. Then, initial one only.)

\_\_\_\_\_ 1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

**OR**

\_\_\_\_\_ 2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

ADD INSTRUCTIONS  
HERE IF YOU WANT  
DIFFERENT  
TREATMENT IN THE  
EVENT YOU ARE  
PREGNANT

INITIAL ONLY ONE,  
DEPENDING ON  
HOW STRICTLY YOU  
WANT YOUR  
TREATMENT  
PREFERENCES  
FOLLOWED

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PART III

**PART III: SIGNATURE AND WITNESSES**

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

SIGN AND DATE  
YOUR DOCUMENT

\_\_\_\_\_  
(Signature of Declarant) (Date)

The declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

YOUR WITNESSES  
MUST SIGN AND  
DATE AND LIST  
THEIR TELEPHONE  
NUMBERS HERE

\_\_\_\_\_  
(Signature of Witness) (Date)

Telephone Number(s): \_\_\_\_\_

\_\_\_\_\_  
(Signature of Witness) (Date)

Telephone Number(s): \_\_\_\_\_

(Note: Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the declarant or otherwise knowingly gain a financial benefit from the declarant's death. Maryland law does not require this document to be notarized.)

ONE WITNESS  
MUST NOT  
KNOWINGLY  
INHERIT ANYTHING  
FROM YOU OR  
OTHERWISE  
KNOWINGLY  
BENEFIT FROM  
YOUR DEATH

**MARYLAND "AFTER MY DEATH" FORM – PAGE 1 OF 3**

**AFTER MY DEATH**

(This form is optional. Fill out only what reflects your wishes.)

By: \_\_\_\_\_  
(Print Name)

Date of Birth: \_\_\_\_\_  
(Month/Day/Year)

**PART I: ORGAN DONATION**

(Initial the ones that you want.)

Upon my death I wish to donate:

- \_\_\_\_\_ Any needed organs, tissues, or eyes.
- \_\_\_\_\_ Only the following organs, tissues, or eyes:

\_\_\_\_\_  
\_\_\_\_\_

I authorize the use of my organs, tissues, or eyes:

- \_\_\_\_\_ For transplantation
- \_\_\_\_\_ For therapy
- \_\_\_\_\_ For research
- \_\_\_\_\_ For medical education
- \_\_\_\_\_ For any purpose authorized by law

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead under legal standards. This document is not intended to change anything about my health care while I am still alive. After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

**PART II: DONATION OF BODY**

\_\_\_\_\_ After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program.

PRINT YOUR NAME  
AND DATE OF  
BIRTH

PART I

INITIAL ONLY ONE

INITIAL ALL THAT  
APPLY

PART II

INITIAL HERE IF  
YOU WANT YOUR  
BODY DONATED  
FOR MEDICAL  
STUDY

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MARYLAND "AFTER MY DEATH" FORM – PAGE 2 OF 3

PART III

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

I want the following person to make decisions about the disposition of my body and my funeral arrangements:

(Either initial the first or fill in the second.)

\_\_\_\_\_ The health care agent who I named in my advance directive.

**OR**

\_\_\_\_\_ This person:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone Numbers: \_\_\_\_\_  
(home and cell)

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Attach additional pages, if needed.)

INITIAL ONLY ONE

PRINT NAME, ADDRESS, AND TELEPHONE NUMBER OF THE PERSON YOU WANT TO MAKE DECISIONS REGARDING DISPOSITION OF YOUR BODY

PRINT ADDITIONAL INSTRUCTIONS HERE, IF ANY

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**MARYLAND "AFTER MY DEATH" FORM – PAGE 3 OF 3**

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**PART 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 Witness) (Date)

Telephone Number(s) \_\_\_\_\_

\_\_\_\_\_  
(Signature of Witness) (Date)

Telephone Number(s) \_\_\_\_\_

PART IV

SIGN AND DATE  
YOUR DOCUMENT  
HERE

HERE YOUR  
WITNESSES SIGN  
AND DATE AND  
PRINT THEIR  
TELEPHONE  
NUMBERS HERE

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*Courtesy of Caring Connections  
1731 King St, Suite 100, Alexandria, VA 22314  
www.caringinfo.org, 800/658-8898*

## You Have Filled Out Your Health Care Directive, Now What?

1. Your Maryland Advance Directive and "After my Death" form are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your Maryland documents.
7. Be aware that your Maryland documents will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives, called "emergency medical services/do not resuscitate orders (EMS/DNR orders)" or "Medical Orders for Life-Sustaining Treatment (MOLST)," are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.** To get information about a physician's order form that allows emergency medical personnel to provide comfort care instead of aggressive interventions, call the Maryland Institute for Emergency Medical Services Systems at (410) 706-4367. You can also download the Maryland EMS/DNR Order at: <http://www.miemss.org>

## Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and Caring Connections allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

**I hope you will show your support for our mission and make a tax-deductible gift today.**

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of \$23, \$47, \$64**, or the most generous amount you can send.

**You can help** us provide resources like this advanced directive FREE by sending in your gift to help others.

**Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.**



**YES!** I want to support the important work of the National Hospice Foundation.

- \$23** helps us provide free advanced directives
- \$47** helps us maintain our free HelpLine
- \$64** helps us provide webinars to hospice professionals

Return to:  
National Hospice Foundation  
PO Box 824401  
Philadelphia, PA 19182-4401

AD\_2015



OR donate online today: [www.caringinfo.org/donate](http://www.caringinfo.org/donate)