CATHOLIC ADVANCE CARE PLAN/HEALTH CARE POWER OF ATTORNEY

I,, pursuant to the Tennessee Health Care Decisions Act (Tenn. Code Ann. Section 68-11-1801 et seq.), hereby reaffirm my belief in the Catholic faith and our profession of one God whose love is shown in Christ Jesus, Savior of the world "the way, the truth and the life" (John 14:6). In his death on the cross and resurrection to new life, Jesus has conquered the ultimate sting of sin and death. Within that faith, I choose to follow the moral teachings of the Catholic Church. Agent/Attorney in Fact: With my Declaration of Faith in mind, I appoint the following individual as my Agent/Attorney in Fact to make my health care decisions if I cannot make decisions for myself, including end-of-life decisions, based on his or her conscience and the teachings of the Catholic Church:		
Address:		
Alternate Agent/Attorney in Fact: If the person named aboappoint as alternate:	ove is unable or unwilling to n	nake health care decisions for me, I
Name: Address:	Phone #:	Relation:
71441055.		
This Advance Care Plan/Health Care Power of Attorney is Care Decisions Act (Tenn. Code Ann. Section 68-11-1801 e Code Ann. Section 34-6-201 et seq.). Accordingly, all acts have the same effect and inure for my benefit and bind me a addition, all acts done by my Agent/Attorney in Fact pursua shall have the same effect and inure to my benefit and bin disabled.	at seq.) and the Durable Power done by my Agent/Attorney and my successors in interest and to this document, during a	r of Attorney for Health Care Act (Tenn. in Fact pursuant to this document shall as if I personally performed said acts. In ny period of my disability or incapacity,
Revocation of Prior Documents: This document revokes executed.	all Powers of Attorney for	health care and Living Wills previously
End-of-Life Decisions: If I am suffering from an illness or c is no reasonable medical expectation of recovery, then my medical decisions necessary to comply with my wishes to medical care, excepting only the administration of medication provide me with comfortable care or to alleviate pain. My sp	Agent/Attorney in Fact is spe honor my Catholic faith inc ons or the performance of any	cifically authorized to make any and all luding withholding and withdrawing all
If my heart stops beating or I stop breathing,		
I wish to pass on naturally in peace and dignity w OR		Jo CPR)
I wish to have resuscitative efforts performed (CP	PR)	
If there is no reasonable expectation of recovery, or if it is de	emed to be excessively burde	nsome,
I do not wish to have artificial hydration and nutri OR I wish to have artificial hydration and nutrition gi		
If there is no reasonable expectation of recovery, or if it is de		nsome,
I wish to have all medical care directed at alleviat	ting pain and providing comfo	rt.
ORI wish to have all medical procedures deemed need during those procedures.	cessary to attempt to cure the	illness while ensuring my comfort
As an alternative to all of the above choices, I do the above procedures and /or treatments.	efer to the conscience of my	Agent/Attorney in Fact with regard to all
(initial decisions above)		

Other instructions, such as burial arrangements, hospice care, etc	
	-
(Attach additional pages if necessary)	
Organ donation (optional): Upon my death, I wish to make the following	ing anatomical gift (please mark one):
☐ Any organ/tissue ☐ My entire body	☐ Only the following organs/tissues:
SIGNATU	URE
Your signature should either be witnessed by two competent adults or you appointed as your Agent, and at least one of the witnesses should your estate.	r notarized. If witnessed, neither witness should be the person
Signature:	DATE:
(Patient) Witnesses:	
1. I am a competent adult who is not named as the Agent. I witnessed the patient's signature on this form.	Signature of witness number 1
2. I am a competent adult who is not named as the Agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.	Signature of witness number 2
This document may be notarized instead of witnessed:	
STATE OF TENNESSEE COUNTY OF	
I am a Notary Public in and for the State and County named above. The (or proved to me on the basis of satisfactory evidence) to be the person before me and signed above or acknowledged the signature above as he appears to be of sound mind and under no duress, fraud, or undue influence.	on who signed as the "patient". The patient personally appeared is or her own. I declare under penalty of perjury that the patient
My commission expires:	Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE CARE PLAN

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your Agent