PENNSYLVANIA
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

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, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare 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 your electronic healthcare record, or 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 PENNSYLVANIA ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, a **Pennsylvania Advance Health Care Directive,** containing four parts, 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.

Part I contains an introduction that describes the uses and effects of this form.

Part II contains a **Durable Health Care Power of Attorney**. This part lets you name someone to make decisions about your medical care—including decisions about life-sustaining treatment—if you can no longer speak for yourself. The durable health care power of attorney is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Part III contains your **Living Will.** Your living will lets you state your wishes about healthcare in the event that you can no longer make your own health care decisions and you are permanently unconscious or have an end-stage medical condition.

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

You may complete Part II, Part III, or both depending on your advance- planning needs. **You must complete Part IV.**

Note: This document will be legally binding only if the person completing it is an individual of sound mind and the individual also is one of the following:

- 18 years or older;
- a high school graduate;
- married; OR
- an emancipated minor.

How do I make my Pennsylvania Advance Health Care Directive legal?

In order to make your advance health care directive legally binding, you must date and sign it, or direct another to do so, in the presence of two witnesses. Both of your witnesses must be 18 years or older and, if you are unable to sign your Directive, neither witness can be the person who signed the Directive on your behalf.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare 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 healthcare decisions for you.

Unless he or she is related to you, you may not appoint as your agent:

- Your attending physician or other health care provider, or
- The owner, operator, or employee of a healthcare facility where you are receiving care.

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

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

You should inform the person you name in Part II, **Durable Health Care Power of Attorney**, that you have appointed him or her as your healthcare agent and discuss your beliefs and values so that your healthcare agent will understand your healthcare objectives, including whether you want to limit or withhold life-sustaining measures in the event that you become permanently unconscious or have an end-stage medical condition. You should also tell your healthcare agent whether you want to donate organs, tissues, eyes or other parts of the body. It is important to understand that if you decide to donate certain parts of the body, it may impact funeral arrangements.

When does my agent's authority become effective?

Your **Durable Health Care Power of Attorney** goes into effect when your doctor determines that you are no longer able to make or communicate your healthcare decisions.

Your **Living Will** goes into effect when your doctor determines that you are no longer able to make or communicate your healthcare decisions, and you are permanently unconscious or have an end-stage medical condition.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

A pregnant patient's Pennsylvania Directive will not be honored, due to restrictions in the state law, unless life-sustaining treatment will not permit the development and live birth of the unborn child, will

be physically harmful to the pregnant woman, or will cause her pain that cannot be alleviated by medication.

Your agent will be bound by the current laws of Pennsylvania as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your Pennsylvania Advance Health Care Directive at any time and in any manner. Your revocation becomes effective when you, or a witness to your revocation, notify your doctor or other healthcare provider.

Unless you specify otherwise, if you have appointed your spouse as your agent, your appointment is automatically revoked if either of you file a divorce action. You may specify on page 7 of the form that you want your spouse to continue to be your agent even if a divorce action is filed if you do not want such an automatic revocation to occur.

In Part III, **Living Will**, you may include instructions regarding end-of life care and your view regarding organ and tissue donation. If your wishes about donating an organ, tissue, or eye change, tell your physician and write a new advance health care directive to replace your old one. If you do not wish to donate a hand, facial tissue or limb, it is important to make that clear in your instructions.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

GENERAL INFORMATION

PART I: INTRODUCTORY REMARKS ON HEALTH CARE DECISION MAKING

You have the right to decide the type of health care you want.

Should you become unable to understand, make or communicate decisions about medical care, your wishes for medical treatment are most likely to be followed if you express those wishes in advance by:

(1) naming a health care agent to decide treatment for you; and

(2) giving health care treatment instructions to your health care agent or health care provider.

An advance health care directive is a written set of instructions expressing your wishes for medical treatment. It may contain a health care power of attorney, where you name a person called a "health care agent" to decide treatment for you, and a living will, where you tell your health care agent and health care providers your choices regarding the initiation, continuation, withholding or withdrawal of life-sustaining treatment and other specific directions.

You may limit your health care agent's involvement in deciding your medical treatment so that your health care agent will speak for you only when you are unable to speak for yourself or you may give your health care agent the power to speak for you immediately. This combined form gives your health care agent the power to speak for you only when you are unable to speak for yourself. A living will cannot be followed unless your attending physician determines that you lack the ability to understand, make or communicate health care decisions for yourself and you are either permanently unconscious or you have an end-stage medical condition, which is a condition that will result in death despite the introduction or continuation of medical treatment. You, and not your health care agent, remain responsible for the cost of your medical care.

If you do not write down your wishes about your health care in advance, and if later you become unable to understand, make or communicate these decisions, those wishes may not be honored because they may remain unknown to others.

A health care provider who refuses to honor your wishes about health care must tell you of his or her refusal and help to transfer you to a health care provider who will honor your wishes.

GENERAL INFORMATION (CONTINUED)

You should give a copy of your advance health care directive (a living will, a health care power of attorney or a document like this one that contains both) to your health care agent, your physicians, family members and others whom you expect would likely attend to your needs if you become unable to understand, make or communicate decisions about medical care. If your health care wishes change, tell your physician and write a new advance health care directive to replace your old one. It is important in selecting a health care agent that you choose a person you trust who is likely to be available in a medical situation where you cannot make decisions for yourself. You should inform that person that you have appointed him or her as your health care agent and discuss your beliefs and values with him or her so that your health care agent will understand your health care objectives.

You may wish to consult with knowledgeable, trusted individuals such as family members, your physician or clergy when considering an expression of your values and health care wishes. You are free to create your own advance health care directive to convey your wishes regarding medical treatment. The following form is an example of an advance health care directive that combines a health care power of attorney with a living will.

NOTES ABOUT THE USE OF THIS FORM

If you decide to use this form or create your own advance health care directive, you should consult with your physician and your attorney to make sure that your wishes are clearly expressed and comply with the law.

If you decide to use this form but disagree with any of its statements, you may cross out those statements.

You may add comments to this form or use your own form to help your physician or health care agent decide your medical care.

This form is designed to give your health care agent broad powers to make health care decisions for you whenever you cannot make them for yourself. It is also designed to express a desire to limit or authorize care if you have an end-stage medical condition or are permanently unconscious. If you do not desire to give your health care agent broad powers, or you do not wish to limit your care if you have an end-stage medical condition or are permanently unconscious, you may wish to use a different form or create your own. YOU SHOULD ALSO USE A DIFFERENT FORM IF YOU WISH TO EXPRESS YOUR PREFERENCES IN MORE DETAIL THAN THIS FORM ALLOWS OR IF YOU WISH FOR YOUR HEALTH CARE

GENERAL INFORMATION (CONTINUED)

AGENT TO BE ABLE TO SPEAK FOR YOU IMMEDIATELY. In these situations, it is particularly important that you consult with your attorney and physician to make sure that your wishes are clearly expressed.

This form allows you to tell your health care agent your goals if you have an end-stage medical condition or other extreme and irreversible medical condition, such as advanced Alzheimer's disease. Do you want medical care applied aggressively in these situations or would you consider such aggressive medical care burdensome and undesirable?

You may choose whether you want your health care agent to be bound by your instructions or whether you want your health care agent to be able to decide at the time what course of treatment the health care agent thinks most fully reflects your wishes and values.

If you are a woman and diagnosed as being pregnant at the time a health care decision would otherwise be made pursuant to this form, the laws of this Commonwealth prohibit implementation of that decision if it directs that life-sustaining treatment, including nutrition and hydration, be withheld or withdrawn from you, unless your attending physician and an obstetrician who have examined you certify in your medical record that the life-sustaining treatment:

(1) will not maintain you in such a way as to permit the continuing development and live birth of the unborn child;

(2) will be physically harmful to you; or

(3) will cause pain to you that cannot be alleviated by medication.

A physician is not required to perform a pregnancy test on you unless the physician has reason to believe that you may be pregnant.

Pennsylvania law protects your health care agent and health care providers from any legal liability for following in good faith your wishes as expressed in the form or by your health care agent's direction. It does not otherwise change professional standards or excuse negligence in the way your wishes are carried out. If you have any questions about the law, consult an attorney for guidance.

This form and explanation is not intended to take the place of specific legal or medical advice, for which you should rely upon your own attorney and physician.

PART II: DURABLE HEALTH CARE POWER OF ATTORNEY

PRINT YOUR NAME AND COUNTY

I,_____, of

_____ County, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me.

Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my health care agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the regulations promulgated there under and any other State or local laws and rules. Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by 45 C.F.R. Pt. 164.

The remainder of this document will take effect when and only when I lack the ability to understand, make or communicate a choice regarding a health or personal care decision as verified by my attending physician. My health care agent may not delegate the authority to make decisions.

CROSS OUT AND INITIAL POWERS YOU DO NOT WANT YOUR AGENT TO HAVE

MY HEALTH CARE AGENT HAS ALL OF THE FOLLOWING POWERS, SUBJECT TO ANY HEALTH CARE TREATMENT INSTRUCTIONS THAT I GIVE IN THIS DOCUMENT (CROSS OUT AND INITIAL ANY POWERS YOU DO NOT WANT TO GIVE YOUR HEALTH CARE AGENT):

1. To authorize, withhold or withdraw medical care and surgical procedures.

2. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.

3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.

4. To hire and fire medical, social service and other support personnel responsible for my care.

5. To take any legal action necessary to do what I have directed.

6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.

7. To authorize or refuse to authorize donation of what we traditional think of as organs (or example, heart, lung, liver, kidney), tissue, eyes or other parts of the body.

8. To authorize or refuse to authorize donation of hands, facial tissue, limbs or other vascularized composite allografts.

APPOINTMENT OF HEALTH CARE AGENT

PRINT THE NAME, RELATIONSHIP, ADDRESS, PHONE NUMBER AND EMAIL ADDRESS OF YOUR AGENT

Health care agent:

_____
(Name and relationship)
Address: _____
Telephone Number: Home _____ Work _____
Email: _____

IF YOU DO NOT NAME A HEALTH CARE AGENT, HEALTH CARE PROVIDERS WILL ASK YOUR FAMILY OR AN ADULT WHO KNOWS YOUR PREFERENCES AND VALUES FOR HELP IN DETERMINING YOUR WISHES FOR TREATMENT.

NOTE THAT YOU MAY NOT APPOINT YOUR DOCTOR OR OTHER HEALTH CARE PROVIDER AS YOUR HEALTH CARE AGENT UNLESS RELATED TO YOU BY BLOOD, MARRIAGE, OR ADOPTION.

If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named. (It is helpful, but not required, to name alternative health care agents.)

PRINT THE NAME, RELATIONSHIP, ADDRESS, PHONE NUMBER AND EMAIL ADDRESS OF YOUR ALTERNATE HEALTH CARE AGENTS

First Alternative Health Care Agent:

_____
(Name and relationship)
Address: _____
Telephone Number: Home _____ Work _____
Email: _____

Second Alternative Health Care Agent:

_____
(Name and relationship)
Address: _____
Telephone Number: Home _____ Work _____
Email: _____

GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL)

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

When making health care decisions for me, my health care agent should think about what actions would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

I offer the following instructions as additional guidance to my health care agent: _____

ATTACH ADDITIONAL PAGES, IF NEEDED

PART III: LIVING WILL

LIVING WILL INFORMATION

CROSS OUT ANY TREATMENT INSTRUCTIONS WITH WHICH YOU DISAGREE

WRITE "I DO WANT" IF YOU WISH TO RECEIVE THESE TREATMENTS

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make or communicate my treatment decisions:

IF I HAVE AN END-STAGE MEDICAL CONDITION (WHICH WILL RESULT IN MY DEATH, DESPITE THE INTRODUCTION OR CONTINUATION OF MEDICAL TREATMENT) OR AM PERMANENTLY UNCONSCIOUS SUCH AS AN IRREVERSIBLE COMA OR AN IRREVERSIBLE VEGETATIVE STATE AND THERE IS NO REALISTIC HOPE OF SIGNIFICANT RECOVERY, ALL OF THE FOLLOWING APPLY (CROSS OUT ANY TREATMENT INSTRUCTIONS WITH WHICH YOU DO NOT AGREE)

1. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing or be habit forming.

2. I direct that all life prolonging procedures be withheld or withdrawn. You may want to consult with your physician and attorney in order to determine whether your designated choices regarding end-of-life care are compatible with anatomical donation. In order to donate an organ your body may need to be maintained on artificial support after you have been declared dead to facilitate anatomical donation. Detailed information about the procedures for being declared brain dead or dead by lack of cardiac function and information about organ donation can be found on the Department of Transportation's publicly accessible Internet website.

3. I specifically do not want any of the following as life prolonging procedures: (If you wish to receive any of these treatments, write "I do want" after the treatment)

Heart-lung resuscitation (CPR) _____
Mechanical ventilator (breathing machine) _
Dialysis (kidney machine) _____
Surgery _____
Chemotherapy _____
Radiation treatment _____
Antibiotics _____

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries, or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery.

TUBE FEEDINGS

INITIAL ONLY ONE

_____ I want tube feedings to be given

OR

_____ I do not want tube feedings to be given

CROSS OUT ANY TREATMENT INSTRUCTIONS WITH WHICH YOU DISAGREE

4. If I have authorized donation of an organ (such as a heart, liver or lung) or a vascularized composite allograft in the next section of this document, I authorize the use of artificial support, including a ventilator, for a limited period of time after I am declared dead to facilitate the donation.

5. I specifically do not want to be on artificial support after I am declared dead

HEALTH CARE AGENT'S USE OF INSTRUCTIONS

INITIAL ONLY ONE

_____ My health care agent must follow these instructions

OR

_____ These instructions are only guidance. My health care agent shall have final say and may override any of my instructions (indicate any exceptions here): _____

_____

_____

_____

If I have not appointed a health care agent, these instructions shall be followed.

LEGAL PROTECTION

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions

SIGN AND DATE

Signature: _____

Date: _____

INFORMATION ABOUT ANATOMICAL DONATION

INFORMATION ABOUT ANATOMICAL DONATION

Donating an organ or other part of the body is a voluntary act. Under Pennsylvania law, you do not have to donate an organ or any other part of your body. It is important to know the effect of organ donation on your decisions about end-of-life care so that your wishes about end-of-life care will be fulfilled. If someone wishes to become an organ donor, the person may be kept on artificial support after the person has been declared dead to facilitate anatomical donation. Detailed information about the procedure for recovering organs and other parts of the body and detailed information about brain death and cardiac death may be found on the Department of Transportation's publicly accessible Internet website.

Under Pennsylvania law, the organ donor designation on the driver's license authorizes the individual to donate what we traditionally think of as organs (for example, hear, lung, liver, kidney) and tissue and does not authorize the individual to donate hands, facial tissue, limbs or other vascularized composite allografts.

Under Pennsylvania law, explicit and specific consent to donate hands, facial tissue, limbs and other vascularized composite allografts is needed. Donation of these parts of the body is voluntary. Information about the procedure to transplant hands, facial tissue and limbs can be found on the Department of Transportation's publicly accessible Internet website. It is important to know that donating a hand, limb or facial tissue may impact funeral arrangements and that an open casket may not be possible.

ORGAN DONATION

INCLUDE ANY SPECIFIC INSTRUCTIONS OR LIMITATIONS REGARDING ORGAN DONATION

SIGN AND DATE IF YOU CHOOSE TO CONSENT TO THIS PROVISION

ORGAN DONATION

I consent to making an anatomical gift. This does not include hands, facial tissue, limb or other vascularized composite allograft, there is another place in this document for me to do so. I also understand the hospital may provide artificial support, which may include a ventilator, after I am declared dead in order to facilitate donation. I consent to making a gift of the following parts of my body for transplantation or research (please insert any limitations you desire on donation of specific organs or tissues or eyes or any limitation on the use of a donated part of the body):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____

Date: _____

INCLUDE ANY LIMITATIONS YOU DESIRE REGARDING DONATION OF HANDS, FACIAL TISSUE, LIMBS OR OTHER VASCULARIZED COMPOSITE ALLOGRAPHS

GIFT OF HANDS, FACIAL TISSUE, LIMBS AND OTHER VASCULARIZED COMPOSITE ALLOGRAFTS

I consent to making a gift of my hands, facial tissue, limbs or other vascularized composite allografts. I also understand that I have the option of requesting reconstructions of my body in preparation for burial and that anonymity of identity may not be able to be protected in the case of donation of hands, facial tissue or limbs. I also understand that burial arrangements may be affected and that an open casket may not be possible. I also understand that the hospital may provide artificial support, which may include a ventilator, after I am declared dead in order to facilitate donation.

Please insert any limitations you desire on donation of hands, facial tissue, limbs or other vascularized composite allografts and whether you request reconstructive surgery before burial:

_____

_____

_____

_____

_____

_____

_____

SIGN AND DATE IF YOU CHOOSE TO CONSENT TO THIS PROVISION

Signature: _____

Date: _____

PRINT YOUR NAME AND THE DATE AND SIGN HERE

SIGN AND DATE IF YOU CHOOSE TO REFUSE TO DONATE ANY PART OF YOUR BODY

REFUSAL TO DONATE ANY PART OF BODY

I do not consent to donating my organs, tissues or any other part of my body, including hands, facial tissue, limbs or other vascularized composite allografts. This provision serves as a refusal to donate any part of my body. This provision also serves as revocation of any prior decision I have made to donate organs, tissues or other parts of my body, including hands, facial tissue, limbs or other vascularized composite allograft made in a prior document, including a driver's license, will, power of attorney, health care power of attorney or other document.

Signature: _____

Date: _____

REFUSAL TO DONATE ANY PART OF BODY

PART IV: SIGNATURE

I, _____(print your name), having carefully read this document, have signed it this _____day of _____, 20_____, revoking all previous health care powers of attorney and health care treatment instructions.

_____
(SIGN FULL NAME HERE FOR HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE TREATMENT INSTRUCTIONS)

YOUR TWO WITNESSES MUST SIGN AND DATE AND PRINT THEIR NAMES HERE

WITNESS SIGNATURE: _____Date: _____

Printed name: _____

WITNESS SIGNATURE: _____Date: _____

Printed name: _____

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)