ooxWord://word/media/image2.pngooxWord://word/media/image3.pngooxWord://word/media/image4.pngooxWord://word/media/image5.pngooxWord://word/media/image6.pngooxWord://word/media/image7.pngooxWord://word/media/image8.pngooxWord://word/media/image9.pngooxWord://word/media/image10.png**Montana Department of Justice**  
 **Office of Consumer Protection**

[**https://dojmt.gov/consumer/end-of-life-registry/**](https://dojmt.gov/consumer/end-of-life-registry/)

•    **in the opinion of my attending physician, I will die in a relatively short time**  
 **without life sustaining treatment that only prolongs the dying process.**

dying process.

in my body unless for comfort.

placed in my stomach to give me food.

may be used to treat a painful infection.

For office use                  
 only

**MONTANA**  
 **END-OF-LIFE REGISTRY**

**My Choices**  
**Advance Directive**

PO Box 201410, Helena, MT  59620-1410  •  Phone: (406) 444-0660 or (866) 675-3314  •  E-mail:[endofliferegistry@mt.gov](mailto:endofliferegistry@mt.gov)

**Full Name:**

Please print

These directions apply only in situations when I am not able to make or communicate my health   
care choices directly. Put an X through any sections you are not completing at this time.

**1.**

**Terminal Conditions (Living Will)**

I provide these directions in accordance with the Montana Rights of the Terminally Ill Act. These   
are my wishes for the kind of treatment I want if I cannot communicate or make my own   
decisions.These directions are only valid if both of the following two conditions exist:

•    **I have a terminal condition, and**

I authorize my Representative, if I have appointed one, to make the decision to provide,   
withhold, or withdraw any health care treatment.

**General Treatment Directions**

Check the boxes that express your wishes:

**□**I provide no directions at this time.

**□**I direct my attending physician to withdraw or withhold treatment that merely prolongs the

I further direct that (check all boxes that apply):

**□**Treatment be given to maintain my dignity, keep me comfortable and relieve pain.   
**□**If I cannot drink, I do not want to receive fluidsthrough a needle or catheter placed

**□**If I cannot eat, I do not want a tubeinserted in my nose or mouth, or surgically

**□**If I have a serious infection, I do not want antibioticsto prolong my life. Antibiotics

I have attached additional directions regarding medical treatment to this form:

**□**Yes

**□**No

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2.  
3.

I revoke my Representative’s authority; or

My Representative becomes unwilling or unable to act

for me; or   
My Representative is my spouse and I become legally separated or

**Chronic Illness or Serious Disability (Optional)**

My chronic illness or disability can complicate an acute illness, but should not be misinterpreted   
as a terminal condition.

Diagnosis

Consult my physician

Name

Phone

Special directions (use additional pages if necessary)

**3.   Health Care Representative (Power of Attorney for Health Care)**

My Representative may make all health care decisions for me as authorized in this document   
and shall be given access to all my medical records. This appointment applies whether I am   
expected to recover or not.

**I wish to appoint a Representative**

**□**Yes

**□** No

**A.  Primary Representative**

I appoint

  as my Representative.

Print Representative’s Full Name

Representative's Address

City

State

Zip

Home Phone

Work Phone

My Representative’s authority is effective when I cannot make health care decisions or   
communicate my wishes. I may revoke this authority at any time I regain these abilities   
(unless my attending physician and any necessary experts determine I am not capable of   
making decisions in my own best interest).

If, for any reason, I should need a guardian of my person designated by a court, I nominate   
my Representative, or Alternate Representative(s), named below.

**B. Alternate Representative(s)**

If:1.

divorced,   
I name the following person(s) as alternates to my Representative in the order listed:

**1.**

**2.**

Print Alternate Representative's Full Name

Print Alternate Representative's Full Name

Address

Address

City

State

Zip

City

State

Zip

Home Phone

Work Phone

Home Phone

Work Phone

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**Signing and Witnessing this Advance Directive**

**A. Your Signature**

Ask two people to watch you sign and have them sign below. If you can, it’s best to sign this   
document in front of a Notary Public.

1.  I revoke any prior health care advance directive or directions.

2.  This document is intended to be valid in any jurisdiction in which it is presented.   
3.  A copy of this document is intended to have the same effect as the original.

4.  Those who act as I have directed in this document shall be free from legal liability for   
 having followed my directions.

5.  If my attending physician is unwilling or unable to comply with my wishes as stated in this   
 document, I direct my care be transferred to a physician who will.

I sign this document on the

 day of

, 20

Signature

Print Full Name

Address

City

State

Zip

Home Phone

Work Phone

**B.  Ask Your Witnesses to Read and Sign**

I declare that I am over the age of 18 and the person who signed this document is personally   
known to me, and has signed these health care advance directives in my presence, and   
appears to be of sound mind and under no duress, fraud or undue influence.

**1.**

**2.**

Signature

Date

Signature

Date

Printed Name

Printed Name

Address

Address

City

State

Zip

City

State

Zip

**C. Notarizing This Document**

STATE OF

 COUNTY OF

On this

 day of

, 20

, the said known to me (or satisfactorily proven) to be the

person named in the foregoing instrument, personally appeared before me, a Notary Public within and for the   
State and County aforesaid, and acknowledged that he or she freely and voluntarily executed the same for the

purposes stated therein.

Notary Public for the State of

Residing at

My commission expires

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**F.  Distributing this Advance Directive**

**□**Kidneys

**C. Donation of Organs at My Death**(check one of the following):

**B. Where I Would Like to be When I Die**

**□**Lungs   
□ Liver         **□**Other(s)

□ Bone Marrow

□ Eyes

□ Skin

**Special Directions**

**A. Spiritual Preferences**

My religion  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  My faith community

Contact person  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I would like spiritual support **□**Yes **□**No

□ My home

□ Hospital

□ Nursing home

□ Other

**□**I do not wish to donate any of my body, organs, or tissue.   
**□**I wish to donate my entire body.

**□**I wish to donate **only**the following (check all that apply):   
 **□**Any organs, tissues, or body parts     □ Heart

**D. After-Death Care**(care of my body, burial, cremation, funeral home preference)

**E. Additional Directions**(use additional pages if necessary)

**Signature**

**Date**

**I plan to deposit this Advance Directive in the Montana End-of-Life Registry:  □**Yes   **□**No

I plan to send copies of this document to the following people or locations:

**Physician:**

**Family Member:**Relationship

Name

Name

Address

Address

City

State

Zip

City

State

Zip

Home Phone

Work Phone

Home Phone

Work Phone

**Hospital:**

**Clergy:**

Name

Name

Address

Address

City

State

Zip

City

State

Zip

Home Phone

Work Phone

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