MEDICAL DECISIONS’ PROTECTION DOCUMENT (“MDPD”)

1. Because it is not usually possible to foresee specific circumstances under which another person may have to make decisions pertaining to my health care, and since it is not feasible for me to know what specific decisions I might make in those circumstances, I have most carefully considered the principles and beliefs upon which I base the decisions that I make for myself. The following paragraphs are intended to direct those who must make decisions for me should I become unable to do so.
2. I therefore direct my appointed representative(s) and all others involved with my medical treatment and care to follow these instructions.
3. I wish to live the lifespan given to me by Almighty God. I direct that all medical and surgical treatments and care, including nutrition and hydration, be given to protect and preserve my life.
4. Do not hasten death. Do not shorten life. Do not do the procedure called the APNEA Test (not a test for sleep apnea).
5. I ask that, even when it seems that death is close, I am provided with ordinary medical treatments and care, including pain relief. However, I refuse any form of palliative care that may entail the medications for pain or sedation that may have, as a consequence, the hastening of my death and I wholly reject any form of so-called “assisted dying” (assisted suicide) (imposed death) whereby death is hastened by a lethal drug.
6. I request that nothing be done that will directly and intentionally impose death; nor should anything be omitted when such omission would directly and intentionally impose death.
7. Do not take any organs for transplantation or any other purpose; neither do I wish to receive organs from other people.
8. I refuse permission to allow cremation and/or incineration after my death, seeking instead to invoke the holy sacrament of Extreme Unction and the full funeral rites of the Traditional Catholic Church in respect of a Traditional Catholic Christian funeral mass and burial.
9. These instructions are binding not only upon my appointed representative (s) but also upon the health care professionals/ facilities having responsibility for my life and health.

10A: Statement of Medical Care Principles

*Those responsible for administering medical treatment and care should pursue the following objectives: sustaining life, restoring health where possible, preventing deterioration in health and alleviating suffering. “Quality of life” assessments should not be used to determine that the person is no longer entitled to due respect, care and treatment. All treatment and care is to be given in accordance with the established medical ethics teachings of the Hippocratic Oath, in harmony with the religious tradition of the patient.*

Signed…………………………………………………………………………………………………………………………..

 Address…………………………………………………………………………………………………………………………

 Signature of the Appointed Representative (s)/Executor……………………………………………………………………...

(***Delete as necessary***).

 Address…………………………………………………………………………………………………………………………

 Telephone/Contact details…………………………………………………………………Date………………………………

MEDICAL DECISIONS’ PROTECTION DOCUMENT (“MDPD”)

I ………………………………………….…………………………. hereby designate and appoint

Name: ……………………………………………………………………….………………………

Address: …………………………………………………………………………….………………

Telephone: Home: ( )………………………………………………………………….………

Telephone: Business: ( )………………………………………………………………………..

Fax / Mobile/E-mail: ……………………………………………………………………………….

**As my appointed representative (s), to make health care decisions for me in the event that I become incapacitated, and only for the duration of that incapacity.**

**Since health care decisions are highly personal, I declare that I have carefully discussed my preferences for medical treatment and care with my appointed representative. Nothing that is stated in this general authority should be taken to exclude advances made in the medical field for treatment and care.**

**I have delegated to my appointed representative the role of assessing (and advocating for) treatment and care for me that is based upon the above instructions for my health care. I charge all those who attend me not to condone any action and/or omission, which alone, or in conjunction with any other act and/or omission, would directly and/or intentionally hasten or cause my death.**

**This general authority is intended to confer immunity on my appointed representative unless the said appointed representative is not acting in compliance with my instructions. This general authority is not intended to confer immunity on any doctor, health care professional, minister of religion and/or health care institution acting in negligence and/or in bad faith. These instructions are binding not only on my appointed representative but also upon any health care personnel and/or institution that shall assume and/or retain responsibility for my life and health.**

**Signature of Patient……………………………………………..Date…………………..**

MEDICAL DECISIONS’ PROTECTION DOCUMENT (“MDPD”)

If the person (s) named as my appointed representative (s) is/are unwilling or unable to act as my representative (s), I appoint as my alternative representative (s):

Name: ……………………………………………………………………………………………….

Address: …………………………………………………………………………………………….

Telephone: Home: ( )………………………………………………………………………….

Telephone: Business: ( )………………………………………………………………………...

Fax / Mobile/E-mail: ………………………………………………………………………………..

By signing here, I/We indicate that I/We understand the purpose and effect of this document:

**Signature ………………………………………………………...Date…………………..**

Witness

I declare that the person who signed and/or acknowledged this general authority is personally known to me. I further declare that s/he signed and/or acknowledged this general authority to act in the matter of their health care, in my presence, and that s/he appears to understand this general authority and to be under no duress, fraud and/or undue influence.

I am not the person appointed as a representative by this general authority, nor am I the person’s health care provider and/or an employee of the person’s health care provider.

Name: ……………………………………………………………………………………………….

Address: …………………………………………………………………………………………….

Telephone: Home: ( )………………………………………………………………………….

Telephone: Business: ( )………………………………………………………………………...

Fax / Mobile/E-mail: ………………………………………………………………………………..

MEDICAL DECISIONS’ PROTECTION DOCUMENT

A copy of this document with the original signatures

(And dated) has been provided to:

My Appointed Representative(s):

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

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

My Doctor (s):

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

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

My Health Care Institution (s):

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

(Hospital, nursing home)

Others:

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

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

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

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**N.B. Be sure to notify ALL holders of copies if you revoke your general authority. Remember that ONLY documents with an original signature are to be considered legally valid. A photocopy of a signed document is to be used for information purposes only.**