MEDICAL TREATMENT PLAN

I, _____, certify that I am the attending physician for _____, of _____, who is presently under my care this _____ day of _____, 20_____.

The declarant, the above named patient, is currently suffering from the following injury, disease or illness:_____
_____
_____

I certify that I have explained to the declarant to the extent he/she is able to understand, and to the available person(s) acting as proxy, the reasonably available alternatives for care and treatment.

I certify that the care and treatment alternatives directed below are:

_____ directed by the declarant; or

_____ that the declarant has a physical or mental condition which renders him/her unable to give personal directions for care and treatment and that the care and treatment alternatives directed below are in my opinion, and in the opinion of the declarant's proxy, what the declarant would probably decide if able to give current directions concerning his/her care and treatment.

Date:_____/_____/_____ **_____**

Attending Physician

-continued-

The following care and treatment or withholding of treatment is directed with respect to the declarant:

_____
_____
_____
_____
_____

_____
_____

Relationship to declarant of any agent signing for declarant **Signature of declarant or authorized agent**

_____
_____
___

Address of signer, including City, County and state of residence

We, the witnesses, certify that each of us is 18 years of age or older; that we personally witnessed the declarant or a proxy sign this directive; that we are acquainted with the declarant and, if the foregoing was signed by a proxy, also the proxy; that we believe that care and treatment alternatives directed above are in the interest of declarant and what declarant has decided or would probably decide for himself/herself if able to give current directions concerning his care and treatment; that neither of us signed the above directive for or on behalf of the declarant; that we are not related to the declarant by blood or marriage nor are entitled to any portion of declarant's estate according to the laws of intestate succession of this or under any Will or Codicil of the declarant; that we are not

agents of any health care facility in which declarant may be a patient at the time of signing this directive.

Witness #1	**Witness #2**
_____	_____
Signature	**Signature**
_____	_____
Name (please print)	**Name (please print)**
_____	_____
Address	**Address**
_____	_____
City, State, Zip Code	**City, State, Zip Code**