General Instructions

- **IMPORTANT**: Initial all portions that apply.
- Add any allergies or medications or treatments that you don't want administered in the blank lines in the fillable area. Don't forget to initial if you add information. If you do not add additional information, DO NOT initial the blank lines area.
- Notarize the document: ONLY SIGN THE DIRECTIVE DOCUMENT AND LETTER BEFORE THE NOTARY.
- Make at least 10 copies (for extras).

    1. Mail to the hospital the letter and the original Directive copy. Use a Priority Mailer (Certified Mail with Return Receipt Requested). Address the Priority Mailer to the CEO at the physical hospital address.
    2. Courier Service a copy of the above letter and copy of the Directive to the CEO at the physical hospital address.
    3. Give a copy of the Directive to the Attending Physician.
    4. Give a copy of the Directive to the Nurse.
    5. Keep the additional copies for your records.

To: All Healthcare Providers for _________________________with Date of Birth_________

PATIENT NAME DOB

RE: DIRECTIVES FOR CARE

CC: All representatives, subsidiaries, parent companies, attorneys, Chief of Staff, Chief Quality Officer, Medical Executive Committee, Board of Trustees, Chief Executive Officer

Attached are advanced directives related to my care.

Please ensure that this legal notification is clearly accessible in the electronic medical record at all times.

Thank you in advance for your attention to this matter.

___________________________ _________________

Name Date

Address__________________________________

Phone____________________________

Email____________________________

NOTARIZED ACKNOWLEDGEMENT

State of:____________________

County of:____________________

PERSONALLY came and appeared before me, the undersigned Notary, within the

named_______________, who is a resident of __________________County, State of

________________.

DIRECTIVE TO PHYSICIANS

I, ______________________________, recognize that the best health care is based upon a partnership of trust and communication and shared decision making with my physician. My physician and I will make health care or treatment decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored as my carefully planned and intentional wishes:

_____**I REQUEST AND CONSENT** to the using all life-saving measures.

_____**I REQUEST AND CONSENT** to the use of 1mg of Budesonide via nebulizer every 4 to 6 hours for COVID 19 or COVID19 variant diagnosis with respiratory issues.

_____**I DO NOT CONSENT** to the use of medications without my legal surrogate being informed of each medication's risks, benefits, and alternatives **BEFORE** they are ordered.

_____**I DO NOT CONSENT** to the use of Remdesivir, or its generic called Veklury, or any drug related to Remdesivir or Veklury under any circumstances.

_____**I DO NOT CONSENT** to the use of Baricitinib, or its brand name Olumiant, for COVID19 or COVID 19 variant.

_____**I DO NOT CONSENT** to the use of Vancomycin without prior consultation with my legal surrogate regarding the risks, benefits, and alternatives to Vancomycin.

_____**I DO NOT CONSENT** to receiving any vaccine or booster for COVID19 or COVID 19 variant.

_____**I DO NOT CONSENT** to receiving the seasonal Flu vaccine.

_____**I DO NOT CONSENT** to receiving the Pneumococcal vaccine.

_____**I DO NOT CONSENT** to a ventilator in the case of a COVID19 or COVID19 variant diagnosis without consultation with my legal surrogate regarding the risks, benefits, and alternatives **PRIOR** to the implementation of the ventilator.

_____**I DO NOT CONSENT** to a Do Not Resuscitate (DNR) order.

____**I DO NOT CONSENT** to medications related to any COVID19 protocol or COVID19 variant protocol for without my legal surrogate first conducting an independent evaluation regarding side effects or risks associated with the COVID 19 protocol or COVID19 variant protocol medications. Only my legal surrogate, may approve COVID19 Protocol medications or COVID19 variant protocol medications. *Under no circumstances should any COVID19 protocol medication or COVID19 variant protocol medication, or COVID19 treatment plan medication or COVID19 variant treatment plan medication, be given without my legal surrogate's specific approval for each and every medication.*

____I ALSO **DO NOT CONSENT** TO THE FOLLOWING:
____

____

DIRECTIVE TO PHYSICIANS

______If the facility does not allow for the use of any alternative medical treatments for COVID19 or COVID19 variant, I direct my legal surrogate to discharge me to another facility or level of care. Should I be discharged to a hospice level of care, I direct my legal surrogate that I be provided oxygen, medication, and any other equipment necessary for comfort.

______ In the event that new medications or treatment options for COVID19 or COVID19 variant are made available, I direct my legal surrogate to conduct an independent evaluation regarding the side effects or risks associated with any new medications or treatment options **PRIOR** to consenting to the administration of new medications or treatments.

____I direct my legal surrogate to implement alternative treatments for COVID19 and COVID19 variants (like those offered as alternative protocols including Ivermectin and Hydroxychloroquine).

This directive will remain in effect until I revoke it. No other person may do so.

___________________________ ________ ______________________
Signature Initials Date:

NOTARIZED ACKNOWLEDGEMENT

State of:____________________

County of:____________________

PERSONALLY came and appeared before me, the undersigned Notary, within the

named _______________, who is a resident of __________________County, State of

________________.