

# MEDICAL TREATMENT PLAN

I, \_\_\_\_\_, certify that  
(Print clearly)

I am the attending physician for \_\_\_\_\_,  
Of \_\_\_\_\_, who is presently under my  
care this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_\_.

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

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

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\_\_\_\_\_  
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 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

