Declarant：

Advance Decision

After completing the 「Advance Care Planning」 consultation process, **I** ______________[printed name] verify I fully understand the rights afforded by the Patient Right to Autonomy Act, which allow patients meeting certain clinical criteria to accept or refuse life-sustaining treatment and/or artificial nutrition and hydration. I affirm that the attached advance directives (e.g., Part 1, Part 2, and any Appendices) reflect my desired end-of-life medical care preferences. Furthermore, I hereby express my hopes my family and friends will respect the decisions I have made.

Declarant

Name: ______________________________ Signature: ______________________________

NIC/ARC/Passport No.: ______________________________ Phone No.: ______________________________

Address: ____

Date (YYYY.MM.DD): ______________________________ Time: ______________(AM/PM)

Witness or Notary*

Please choose one of the following options to legally execute the advance directive:

☐ 1. Two physically present witnesses:

Witness 1

Printed Name: ______________________________ Relation to patient: ______________________

Phone No.: ______________________________ NIC/ARC/Passport No.: ______________________

Signature: ______________________________ Date (YYYY.MM.DD): ______________________

Witness 2

Printed Name: ______________________________ Relation to patient: ______________________

Phone No.: ______________________________ NIC/ARC/Passport No.: ______________________

Signature: ______________________________ Date (YYYY.MM.DD): ______________________

☐ 2. Notary

Notary use only
Date (YYYY.MM.DD) ____________________

*Please note:

1. Witnesses must be of full disposing capacity and be physically present to witness the advance directive is signed voluntarily and free of external coercion (subparagraph 2, Paragraph1, Article 9 of the Patient Right to Autonomy Act.)
2. The declarant's designated health care agent(s), members of the responsible medical team, legatees (apart from the declarant's heirs), legatees of the declarant's remains or organs, and other persons who may benefit from the death of the declarant are ineligible to serve as witnesses. (Paragraph 4 of Article 9).
3. Notaries have the authority to notarize juristic acts and facts related to private rights upon the application of directly related parties or other indirectly related persons. They also have the authority to attest private documents. Notaries may also attest the following documents upon the application of directly related parties or other indirectly related persons: (1) Official documents in their original form that involve facts related to private rights and where the applicants indicate the documents will be used overseas. (2) Transcriptions or photocopies of official or private documents.

Declarant:

Part I:

Medical Care Options

Clinical Condition	Care Option	Medical care wishes/decisions (Only one option may be selected per row)
1. The patient is terminally ill	Life-sustaining treatment	1. ☐ I do not wish to receive life-sustaining treatment. 2. ☐ I wish to receive attempts at life-sustaining treatment for ______________ [period of time], at which point attempts should cease. At any point during the specified period of time, I or my healthcare agent may express the desire to cease treatment. 3. ☐ If I am unconscious or unable to express my wishes clearly, my healthcare agent may decide on my behalf. 4. ☐ I wish to receive life-sustaining treatment.
	Artificial nutrition & hydration	1. ☐ I do not wish to receive artificial nutrition and hydration. 2. ☐ I wish to receive attempts at artificial nutrition and hydration for ______________ [period of time], at which point attempts should cease. At any point during the specified period of time, I or my healthcare agent may express the desire to cease treatment. 3. ☐ If I am unconscious or unable to express my wishes clearly, my healthcare agent may decide on my behalf. 4. ☐ I wish to receive artificial nutrition and hydration.
2. The patient is in an irreversible coma	Life-sustaining treatment	1. ☐ I do not wish to receive life-sustaining treatment. 2. ☐I wish to receive attempts at life-sustaining treatment for ______________ [period of time], at which point attempts should cease. At any point during the specified period of time, my healthcare agent may express the desire to cease treatment. 3. ☐ My healthcare agent may decide on my behalf. 4. ☐ I wish to receive life-sustaining treatment.
	Artificial nutrition & hydration	1. ☐I do not wish to receive artificial nutrition and hydration. 2. ☐ I wish to receive attempts at artificial nutrition and hydration for ______________ [period of time], at which point attempts should cease. At any point during the specified period of time, my healthcare agent may express the desire to cease treatment. 3. ☐ My healthcare agent may decide on my behalf. 4. ☐ I wish to receive artificial nutrition and hydration.
3. The patient is in permanent vegetative state	Life-sustaining treatment	1. ☐ I do not wish to receive life-sustaining treatment. 2. ☐ I wish to receive attempts at life-sustaining treatment for ______________ [period of time], at which point attempts should cease. At any point during the specified period of time, I or my healthcare agent may express the desire to cease treatment. 3. ☐ If I am unconscious or unable to express my wishes clearly, my healthcare agent may decide on my behalf. 4. ☐ I wish to receive life-sustaining treatment.
	Artificial nutrition & hydration	1. ☐ I do not wish to receive artificial nutrition and hydration. 2. ☐ I wish to receive attempts at artificial nutrition and hydration for ______________ [period of time], at which point attempts should cease. At any point during the specified period of time, my healthcare agent may express the desire to cease treatment. 3. ☐ My healthcare agent may decide on my behalf. 4. ☐ I wish to receive artificial nutrition and hydration.

Declarant：

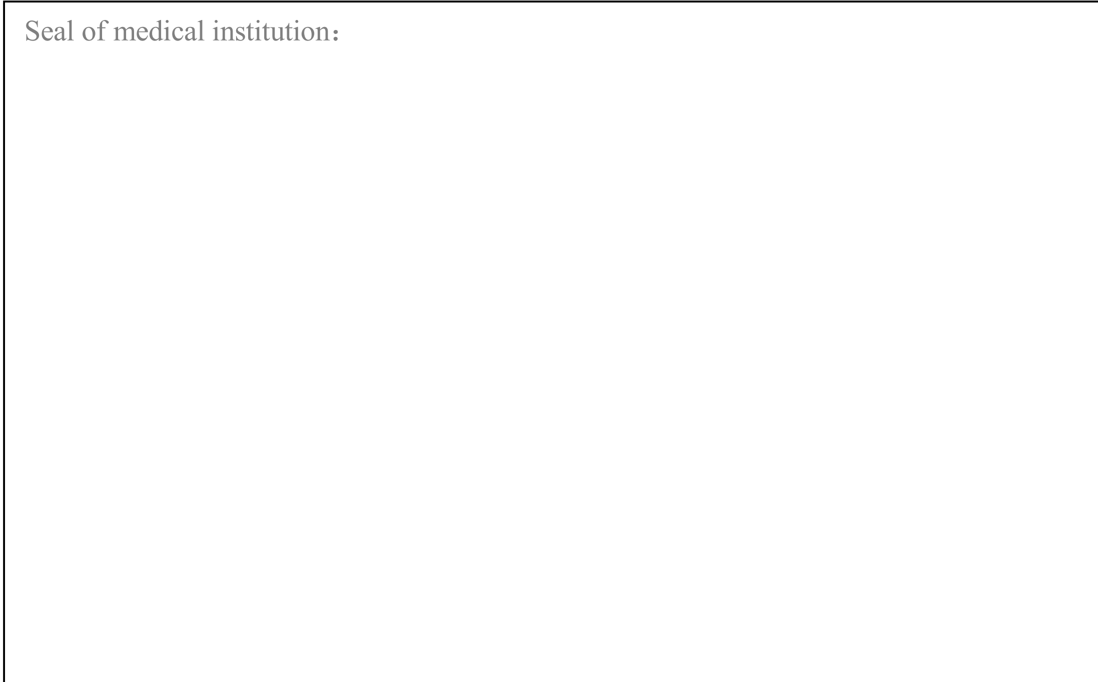
Clinical Condition	Care Option	**Medical care wishes/decisions** **(Only one option may be selected per row)**
4. The patient is suffering from severe dementia	Life-sustaining treatment	1. ☐ I do not wish to receive life-sustaining treatment. 2. ☐ I wish to receive attempts at life-sustaining treatment for ______________ [period of time], at which point attempts should cease. At any point during the specified period of time, my healthcare agent may express the desire to cease treatment. 3. ☐My healthcare agent may decide on my behalf. 4. ☐ I wish to receive life-sustaining treatment.
	Artificial nutrition & hydration	1. ☐ I do not wish to receive artificial nutrition and hydration. 2. ☐ I wish to receive attempts at artificial nutrition and hydration for ______________ [period of time], at which point attempts should cease. At any point during the specified period of time, my healthcare agent may express the desire to cease treatment. 3. ☐ My healthcare agent may decide on my behalf. 4. ☐ I wish to receive artificial nutrition and hydration.
5. Other disease conditions, announced by the central competent authority.	Life-sustaining treatment	1. ☐ I do not wish to receive life-sustaining treatment. 2. ☐ I wish to receive attempts at life-sustaining treatment for ______________ [period of time], at which point attempts should cease. At any point during the specified period of time, I or my health care agent may express the desire to cease treatment. 3. ☐ If I am unconscious or unable to express my wishes clearly, my health care agent may decide on my behalf. 4. ☐ I wish to receive life-sustaining treatment.
	Artificial nutrition & hydration	1. ☐I do not wish to receive artificial nutrition and hydration. 2. ☐I wish to receive attempts at artificial nutrition and hydration for ______________ [period of time], at which point attempts should cease. At any point during the specified period of time, my health care agent may express the desire to cease treatment. 3. ☐ If I am unconscious or unable to express my wishes clearly, my health care agent may decide on my behalf. 4. ☐ I wish to receive artificial nutrition and hydration.

Declarant：

Part II:

Verification by Medical Institution Providing ACP Consultation

In accordance with the Patient Right to Autonomy Act, this seal hereby certifies the declarant ____ has completed the advance care planning consultation process __________________ [YYYY.MM.DD].


Seal of medical institution：

Date (YYYY.MM.DD)____________________

Declarant：

Appendix: Health Care Agent Designation Form (Optional)

I [print name] ____________________________ hereby designate ___________________ [print name] as my ____-choice [enter priority, e.g., first-choice, second-choice, etc.] to serve as my health care agent and execute the rights specified in Article 10(3) of the Patient Right to Autonomy Act.

[Designated health care agent] **Print name:**____ Date Signed (YYYY.MM.DD):
NIC/ARC/Passport No.: Date of Birth (YYYY.MM.DD): Phone No.: Residential Address:

(If the space allotted in this form is insufficient, please attach additional copies as needed.)

- **Below are articles of the Patient Right to Autonomy Act pertaining to the role of the health care agent:**

Article 10 (Health care agent eligibility and rights)

The health care agent designated by the declarant must be an adult who demonstrates legal capacity and provides written consent to the designations.

Apart from the declarant's heirs, the following persons may not serve as healthcare agents:
1. The declarant's legatees.
2. Legatees of the declarant's remains or organs.
3. Other persons who shall benefit from the death of the declarant.

When the declarant is unconscious or unable to clearly express his or her wishes, the healthcare agent may exercise the following rights on behalf of the declarant:
1. Receiving the information set forth in Article 5.
2. Signing the consent form as set forth in Article 6.
3. Expressing the patient's wishes on his or her behalf in accordance with the contents of the patient's advance decision.

When there are more than two healthcare agents, each of them may represent the declarant independently.

When handling the entrusted matters, the health care agent must provide identity documents to the medical institution or physician.

Article 11 (Health care agent termination/dismissal)

A healthcare agent may terminate the designation at any time in writing.

A healthcare agent shall, ipso facto, be dismissed under any of the following circumstances:

1. If the health care agent becomes mentally impaired due to a disease or an accident after a relevant medical or psychiatric assessment.
2. If the health care agent becomes subject to the adjudication of the commencement of assistance or guardship.

Article 13 (Health care agent amendments)

The declarant must file an application with the central competent authority to renew the registration in the event of any of the following circumstances:
1. Withdrawal or modification of the advance decision.
2. Designation, dismissal, or changing of a health care agent.