ADVANCED MEDICAL DIRECTIVE/LIVING WILL

PRIVACY ACT STATEMENT: Authority to obtain this information is 10 U.S.C. § 8012 and E.O. 9397. Information will be used by legal office personnel to prepare your will. It will not be disseminated outside the legal office and is considered confidential. Disclosure is voluntary.

Carefully consider and provide the requested information. Please call to schedule an appointment (240) 612-5750. Please arrive 15 minutes early for your appointment time or if you are unable to keep your appointment please call to cancel.

YOUR FULL NAME: _____

HOME ADDRESS: _____

HOME PHONE: __(_____)_____ LEGAL STATE OF RESIDENCE: _____

MARITAL STATUS: single ___ married ___ divorced ___ pending divorce ___ widow(er) ___

If married, spouse's full name: _____

MILITARY STATUS: active duty ___ retired ___ family member ____ other ___

YOUR PRIMARY AGENT'S (APPOINTEE) FULL NAME: _____

ADDRESS: _____

HOME PHONE: __(_____)_____ LEGAL STATE OF RESIDENCE: _____

(**OPTIONAL**) YOUR **ALTERNATE** AGENT'S FULL NAME: _____

ADDRESS: _____

HOME PHONE: __(_____)_____ LEGAL STATE OF RESIDENCE: _____

Organ Donation:

_____ I do not wish to donate any of my organs or tissues

_____ I want to donate all of my usable organs and tissues for transplant only

_____ I want to donate all of my usable organs and tissues for all legitimate purposes (transplant, medical, science and education)

_____ Other special request: _____

I wish to express a desire to die at home rather than in a hospital: Yes ____ No ____