Keralty Hospital

ADVANCE DIRECTIVE ACKNOWLEDGMENT

Name: ____

Social Security No: ____________________ Date of Birth: ______________________

Please read the following four statements. Place your initials after each statement.

Initials

1. I have been given written materials about my right to accept or refuse medical treatments. ____________
2. I have been informed of my right to formulate Advance Directives. ____________
3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. ____________
4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and my caregivers to the extent permitted by the law. ____________

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

☐ **I HAVE** executed an Advance Directive.

☐ **I HAVE NOT** executed an Advance Directive.

______________________________	______________________
Signature of Patient	Date / Time
______________________________	______________________
Signature of Witness	Date / Time
______________________________	______________________
Signature of Witness	Date / Time