

**TDCJ HEALTH SERVICES DIVISION
DIRECTIVE TO PHYSICIANS**

Directive made this _____ day of _____ (month, year).

I, <~PATIENT_FIRST_NAME~> <~PATIENT_MIDDLE_INIT~>
<~PATIENT_LAST_NAME~>, TDCJ # <~MRN~> being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth in this directive.

1. If at any time I should have an incurable or irreversible condition caused by injury, disease, or illness certified to be a terminal condition by two medical providers, one of which must be a physician, and if the application of life-sustaining procedures would serve only to artificially postpone the moment of my death, and if my attending physician determines that my death is imminent or will result within a relatively short time without application of life-sustaining procedures, I direct that those procedures be withheld or withdrawn, and that I be permitted to die naturally.
2. In the absence of my ability to give directions regarding the use of those life-sustaining procedures, it is my intention that this directive be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from that refusal.
3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no effect during my pregnancy.
4. This directive is in effect until it is revoked.
5. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.
6. I understand that I may revoke this directive at any time.

SIGNED _____

DATE _____

(City, County, and State of Residence)

I-71.2 Attachment A

Effective: 1/4/2012

Reviewed: 10/2021

FIRST WITNESS:

WITNESS _____

DATE _____

SECOND WITNESS:

I am not related to the declarant by blood or marriage. I would not be entitled to any portion of the declarant's estate on the declarant's death. I am not the attending physician of the declarant or an employee of the attending physician. I am not a patient in the health care facility in which the declarant is a patient. I have no claim against any portion of the declarant's estate on the declarant's death. Furthermore, if I am an employee of a health facility in which the declarant is a patient, I am not involved in providing direct patient care to the declarant and am not directly involved in the financial affairs of the health facility.

WITNESS _____

DATE _____

Health and Safety Code 166.003

HSA-58