# Religious-Specific Advance Directive Form

## Personal Information

Full Name

Date of Birth

Address

Phone Number

Religion / Faith Tradition

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## Health Care Proxy / Agent

Name of Health Care Proxy / Agent

Relationship to You

Contact Information

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## Religious/Spiritual Beliefs Affecting Medical Care

Please specify any religious or spiritual beliefs that should guide your health care decisions:

Religious practices, rituals, or restrictions you wish to be observed:

Clergy or Spiritual Leader to be contacted (Name & Contact Information):

## Medical Treatments

Life-sustaining Treatments (artificial ventilation, feeding tubes, resuscitation, etc.):

Treatments or procedures expressly permitted or prohibited by your religion or you personally:

Other Wishes or Instructions Related to Religious Observance and Medical Care:

## Signatures

Signature

Date

Witness Signature

Witness Signature