DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES REGARDING COVID19 or VARIANTS THEREOF AND TREATMENT PROTOCOLS

DIRECTIVE

I, _____, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care or treatment decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness or injury, I direct that the following treatment preferences be honored:

_____ If I am diagnosed with COVID 19, a variant or afflicted with an ailment derived thereof, either determined through testing positive or am determined to be presumptively positive as defined by my symptoms. I intentionally and specifically reject the use of Remdesivir or the use of a ventilator as a treatment option or any other treatment method that is being utilized that is resulting in a high injury or death rate.

_____ If treatment is necessary because I have received the COVID19 or any subsequent variant vaccine, I hereby revoke traditional treatment and direct my agent to seek alternative treatment by professionals treating patients and side effects caused by the vaccine.

_____If the facility does not allow for the use of any alternative medical treatments, I direct my agent to have me discharged and placed on HOSPICE CARE as opposed to being treated with the ventilator or Remdesivir. If I am discharged, I direct that I be provided oxygen and any other necessary equipment for comfort.

_____I do not consent to receiving any vaccine for COVID19 while be admitted to any medical or psychiatric facility.

_____ In the event that new medications or treatment options for COVID19 are made available. I direct my Medical Power of Attorney or surrogate to conduct an independent evaluation regarding the side effects or risks associated with any new medications or treatment options prior to consenting to the administration.

If a medical professional disregards my wishes and refuses to cooperate, I specifically request that a criminal referral be made for assault on my person, false imprisonment and negligent homicide if I should pass away. I have educated myself on the COVID19 pandemic and am aware that the government protocols are life threatening and that the medical establishment is knowingly causing harm.

If the person named as agent in my Medical Power of Attorney is not available, or if I

have not designated a spokesperson, I understand that a spokesperson will be chosen for me following standards specified by law if applicable. If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I specifically direct my spokesperson to seek alternative treatments (like those offered as alternative protocols including Ivermectin and Hydroxychloroquine) I understand that under law this directive may have no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

My residence address is _____.

SIGNED on _____, 2022.

_____
Declarant/Date

STATE OF _____ §
§
COUNTY OF _____ §

Witnessed **Before Me**, the undersigned authority, on this day personally appeared _____, known to me to be the Declarant whose name is subscribed to the foregoing instrument in her capacity, and, said person being by me duly sworn, the Declarant _____, declared to me in my presence that said instrument is her/his Directive to Physicians and Family or Surrogates regarding COVID 19 or any variants thereof, and that she/ he had willingly and voluntarily made and executed it as her free act and deed for the purposes therein expressed.

_____
Declarant/Date

SUBSCRIBED AND ACKNOWLEDGED BEFORE ME by the said Declarant, _____, on this the ____ day of _____, 20

Notary Public, State of _____

OR

Two Competent Adult Witness:

_____Date:_____

_____Date:_____

The Following persons *may not* act as one of the witnesses:

1. The person you have designated as your agent;
2. A person related to you by blood or marriage;
3. A person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;
4. Your attending physician;
5. An employee of your attending physician;
6. An employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility;
7. A person who, at the time this physician directive is executed, has a claim against any part of your estate after your death.