

# My Advance Care Plan

Have the TALK – leave no doubt with your family about your healthcare wishes!

- ✓ Use the attached form to document your healthcare wishes.
- ✓ Remember that the most important part of making medical choices is to TALK about them!
- ✓ TALK about your Advance Care Plan with your family and your Healthcare Agents.
- ✓ TALK about it with your doctor.

If you have questions about making medical choices or completing your Advance Care Plan, call the Sentara Center for Healthcare Ethics at (757) 252-9550 for assistance.

Atención: si habla español, tiene a su disposición servicios lingüísticos gratuitos. Llame al 844-809-6648.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 844-809-6648 번으로 전화해 주십시오.

注意: 如果您讲中文普通话, 则将为您提供免费的语言辅助服务。请致电 844-809-6648。

*ATTENTION: Language assistance services are available to you free of charge. Call 844-809-6648.*

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*Sentara complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.*

## THE U.S. LIVING WILL REGISTRY

This service is provided by Sentara FREE of charge to our community. You can store your Advance Care Plan on the Registry so it will be available to any health care provider in Virginia and North Carolina as well as any providers across the U.S. Once registered, you will receive an acknowledgment along with a wallet card and stickers for your ID cards that will alert medical professionals that you have an Advance Care Plan on file with the Registry and the 800 number so they can retrieve it.

If you want to have your document registered, you must complete the U.S. Living Will Registry Registration Agreement, giving the Registry permission to store your Advance Care Plan and provide it to any healthcare facility that requests a copy, and attach your Advance Care Plan.

## What do I do with my ACP?

1. Make enough copies\* and provide one each to:
  - a. Your appointed Healthcare Agents
  - b. Family members
  - c. Doctor
  - d. The US Living Will Registry through the Sentara Center for Healthcare Ethics\*\*\*
2. Keep the original yourself in a safe and accessible place.
3. \*\*\*Mail a copy of your document to:

The Sentara Center for Healthcare Ethics  
4705 Columbus Street, Suite 303  
Virginia Beach VA 23462  
or fax to our secure line at 757-995-7337

\*Copies are the same as the original in Virginia

# U.S. Living Will Registry® Registration Agreement

SOURCECODE: 36901001



## Registrant's Identifying Information (Please print clearly)

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Suffix \_\_\_\_\_

Social Security# XXX - XX - \_\_\_\_\_ Date of Birth Month \_ Day \_ Year \_\_\_\_ (4 digits)

Email address for Registrant or Emergency Contact: \_\_\_\_\_

\* Annual update reminders will be sent via email (email addresses will not be shared or sold)

Street Address \_\_\_\_\_ Apt # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: ( \_ ) \_ - \_\_\_\_\_ Alternate Phone: ( \_ ) \_ - \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone: ( \_ ) \_ - \_\_\_\_\_ Alternate Phone: ( \_ ) \_ - \_\_\_\_\_

I, \_\_\_\_\_ ("Registrant" or "I"), authorize U.S. Living Will Registry®, with offices at 808 South Ave. West, P.O. Box 2789 Westfield, NJ 07091-2789 ("Registry"), to electronically store a copy of my advance directive(s) provided to Registry with this registration form or subsequently, including but not limited to a living will, health care proxy, durable power of attorney for health care and/or financial matters, Medical or Physician Orders for Scope of Treatment (POST) organ donation wishes and emergency contact information ("Advance Directives"). I further authorize the Registry to make available a copy of the stored Advance Directive(s) to any health care provider or other person believed charged with giving effect to my Advance Directive(s) or assisting in same, who requests it in conjunction with my care, provided such a request is consistent with the Registry's policies and procedures, or as deemed advisable by the Registry in an emergency situation, or as required by law. The Advance Directive(s) that I am providing is my current, effective Advance Directive(s), and was signed and witnessed in accordance with the law of the state of my residence.

I hereby authorize Registry to make available a copy of my Advance Directive(s) to hospitals, physicians, or other health care providers involved with my care, or anyone who has access to the wallet identification ("ID") card provided to me by Registry. I understand this authorization is voluntary. I agree to notify Registry immediately if I decide to revoke or change my Advance Directive(s) stored with Registry and to provide Registry with a copy of any additional Advance Directive(s) that I sign. I understand that unless I terminate this authorization or inform Registry of revocation or changes to my Advance Directive(s), the Advance Directive(s) stored with Registry will be provided to health care providers in accord with Registry policies and practices.

I understand that Registry makes no representations about the validity of my Advance Directive(s) under federal or state law and that Registry bears no responsibility for the actions taken by health care providers in relation to my Advance Directive(s). I hereby waive any and all legal claims against Registry for the actions and omissions by any health care providers who receive a copy of my Advance Directive(s) from Registry and for any damages arising from the transmission or disclosure of the Advance Directive(s) I provide to Registry. Registry shall not be liable for the loss, destruction or unavailability of all or part of my Advance Directive(s).

I understand that I may revoke this authorization at any time by giving written notice of my revocation to Registry. This Agreement will remain in force until revoked by me or until terminated in accordance with the agreement between me and Registry or until registration is cancelled pursuant to the Registry's policies and procedures. When the Agreement is terminated, I understand that Registry will remove my Advance Directive(s) from its files.

I understand that anyone who gains access to my wallet ID card provided by Registry can use it to gain access to my Advance Directive(s) and personal information stored with Registry, and I will not hold the Registry liable for such authorized or unauthorized access.

I hereby agree to the terms set forth herein.

X \_\_\_\_\_

Signature of Registrant

DATED: / /