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Sequence Number: 05-02-16  
 Notice ID(s): 2510-2524  
 File Date: 5/3/16

# Notice of Rulemaking Hearing

Hearings will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, T.C.A. § 4-5-204. For questions and copies of the notice, contact the person listed below.

<b>Agency/Board/Commission:</b>	Board for Licensing Health Care Facilities
<b>Division:</b>	
<b>Contact Person:</b>	Kyonzte Hughes-Toombs
<b>Address:</b>	665 Mainstream Drive, Nashville, Tennessee 37243
<b>Phone:</b>	(615) 741-1611
<b>Email:</b>	Kyonzte.Hughes-Toombs@tn.gov

Any Individuals with disabilities who wish to participate in these proceedings (to review these filings) and may require aid to facilitate such participation should contact the following at least 10 days prior to the hearing:

<b>ADA Contact:</b>	ADA Coordinator
<b>Address:</b>	710 James Robertson Parkway, Andrew Johnson Building, 5 <sup>th</sup> Floor, Nashville, Tennessee 37243
<b>Phone:</b>	(615) 741-6350
<b>Email:</b>	Tina.M.Harris2@tn.gov

**Hearing Location(s)** (for additional locations, copy and paste table)

Address 1:	Metro Center
Address 2:	665 Mainstream Drive – Iris Conference Room
City:	Nashville, Tennessee
Zip:	37228
Hearing Date :	09/07/16
Hearing Time:	9:00 A.M. <input checked="" type="checkbox"/> CST/CDT <input type="checkbox"/> EST/EDT

**Additional Hearing Information:**

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**Revision Type (check all that apply):**

- Amendment
- New
- Repeal

**Rule(s)** (ALL chapters and rules contained in filing must be listed. If needed, copy and paste additional tables to accommodate more than one chapter. Please enter only **ONE** Rule Number/Rule Title per row.)

Chapter Number	Chapter Title
1200-08-01	Standards for Hospitals
Rule Number	Rule Title

1200-08-01-.15	Appendix I
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<b>Chapter Number</b>	<b>Chapter Title</b>
1200-08-02	Standards for Prescribed Child Care Centers
<b>Rule Number</b>	<b>Rule Title</b>
1200-08-02-.14	Appendix I

<b>Chapter Number</b>	<b>Chapter Title</b>
1200-08-06	Standards for Nursing Homes
<b>Rule Number</b>	<b>Rule Title</b>
1200-08-06-.16	Appendix I

<b>Chapter Number</b>	<b>Chapter Title</b>
1200-08-10	Standards for Ambulatory Surgical Treatment Centers
<b>Rule Number</b>	<b>Rule Title</b>
1200-08-10-.15	Appendix I

<b>Chapter Number</b>	<b>Chapter Title</b>
1200-08-11	Standards for Home for the Aged
<b>Rule Number</b>	<b>Rule Title</b>
1200-08-11-.14	Appendix I

<b>Chapter Number</b>	<b>Chapter Title</b>
1200-08-15	Standards for Residential Hospices
<b>Rule Number</b>	<b>Rule Title</b>
1200-08-15-.15	Appendix I

<b>Chapter Number</b>	<b>Chapter Title</b>
1200-08-24	Standards for Birthing Centers
<b>Rule Number</b>	<b>Rule Title</b>
1200-08-24-.14	Appendix I

<b>Chapter Number</b>	<b>Chapter Title</b>
1200-08-25	Standards for Assisted-Care Living Facilities
<b>Rule Number</b>	<b>Rule Title</b>
1200-08-25-.17	Appendix I

<b>Chapter Number</b>	<b>Chapter Title</b>
1200-08-26	Standards for Home Care Organizations Providing Home Health Services
<b>Rule Number</b>	<b>Rule Title</b>
1200-08-26-.15	Appendix I

<b>Chapter Number</b>	<b>Chapter Title</b>
1200-08-27	Standards for Home Care Organizations Providing Hospice Services
<b>Rule Number</b>	<b>Rule Title</b>
1200-08-27-.15	Appendix I

<b>Chapter Number</b>	<b>Chapter Title</b>
1200-08-28	Standards for HIV Supportive Living Centers
<b>Rule Number</b>	<b>Rule Title</b>
1200-08-28-.15	Appendix I

<b>Chapter Number</b>	<b>Chapter Title</b>
1200-08-32	Standards for End Stage Renal Dialysis Clinics
<b>Rule Number</b>	<b>Rule Title</b>
1200-08-32-.15	Appendix I

<b>Chapter Number</b>	<b>Chapter Title</b>
1200-08-34	Standards for Home Care Organizations Providing Professional Support Services
<b>Rule Number</b>	<b>Rule Title</b>
1200-08-34-.15	Appendix I

<b>Chapter Number</b>	<b>Chapter Title</b>
1200-08-35	Standards for Outpatient Diagnostic Centers
<b>Rule Number</b>	<b>Rule Title</b>
1200-08-35-.15	Appendix I

<b>Chapter Number</b>	<b>Chapter Title</b>
1200-08-36	Standards for Adult Care Homes-Level 2
<b>Rule Number</b>	<b>Rule Title</b>
1200-08-36-.18	Appendix I

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to <http://state.tn.us/sos/rules/1360/1360.htm>)

Chapter 1200-08-01  
Standards for Hospitals

Amendments

Rule 1200-08-01-.15 Appendix I is amended by deleting paragraph (2) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

(2) Advance Directive for Health Care Form

**ADVANCE DIRECTIVE FOR HEALTH CARE\***  
(Tennessee)

**Instructions:** Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or

more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	<b>CPR (Cardiopulmonary Resuscitation):</b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

**Part 3** Other instructions, such as hospice care, burial arrangements, etc.: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional pages if necessary)

**Part 4 Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

- Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_  
 \_\_\_\_\_  
 No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

- I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form. \_\_\_\_\_  
 Signature of witness number 1
- I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form. \_\_\_\_\_  
 Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
 COUNTY OF \_\_\_\_\_  
 SS-7037 (July 2014)

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

Chapter 1200-08-02  
Standards for Prescribed Child Care Centers

Amendments

Rule 1200-08-02-.14 Appendix I is amended by deleting paragraph (2) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

(2) Advance Directive for Health Care Form

**ADVANCE DIRECTIVE FOR HEALTH CARE\***  
(Tennessee)

**Instructions:** Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be

willing to live with if given adequate comfort care and pain management. By marking “no” below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked “no” above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking “yes” below, I have indicated treatment I want. By marking “no” below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	<b>CPR (Cardiopulmonary Resuscitation):</b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient’s stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

**Part 3** Other instructions, such as hospice care, burial arrangements, etc.: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Attach additional pages if necessary)

**Part 4 Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

- Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_
- No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults (“Block A”) **or** by a notary public (“Block B”).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

\_\_\_\_\_  
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

\_\_\_\_\_  
Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

Chapter  
1200-08-06

Standards for Nursing Homes

Rule 1200-08-06-.16 Appendix I is amended by deleting paragraph (2) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

(2) Advance Directive for Health Care Form

**ADVANCE DIRECTIVE FOR HEALTH CARE\***  
(Tennessee)

**Instructions:** Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking “yes” below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking “no” below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked “no” above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking “yes” below, I have indicated treatment I want. By marking “no” below, I have indicated treatment I **do not want**.

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Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient’s stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

**Part 3** Other instructions, such as hospice care, burial arrangements, etc.: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional pages if necessary)

**Part 4 Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_

No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

\_\_\_\_\_  
Signature of witness number 1

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\_\_\_\_\_  
Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

Amendments

Rule 1200-08-10-.15 Appendix I is amended by deleting paragraph (2) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

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(Tennessee)

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Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	<b>CPR (Cardiopulmonary Resuscitation):</b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing
Yes	No	

		assistance.
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

**Part 3** Other instructions, such as hospice care, burial arrangements, etc.: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional pages if necessary)

**Part 4** Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

- Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_  
 \_\_\_\_\_  
 No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form. \_\_\_\_\_  
 Signature of witness number 1
2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form. \_\_\_\_\_  
 Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
 COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

Chapter 1200-08-11  
Standards for Homes for the Aged

Amendments

Rule 1200-08-11-.14 Appendix I is amended by deleting paragraph (2) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

(2) Advance Directive for Health Care Form

**ADVANCE DIRECTIVE FOR HEALTH CARE\***  
(Tennessee)

**Instructions:** Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an unacceptable quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not

Yes	No	recognize loved ones or cannot have a clear conversation with them.
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	<b>CPR (Cardiopulmonary Resuscitation):</b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

**Part 3** Other instructions, such as hospice care, burial arrangements, etc.: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional pages if necessary)

**Part 4 Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

- Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_  
 \_\_\_\_\_  
 No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form. \_\_\_\_\_  
 Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

\_\_\_\_\_  
Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1801 through 68-11-815.

Chapter 1200-08-15  
Standards for Residential Hospices

Amendments

Rule 1200-08-15-.15 Appendix I is amended by deleting paragraph (2) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

(2) Advance Directive for Health Care Form

**ADVANCE DIRECTIVE FOR HEALTH CARE\***  
(Tennessee)

**Instructions:** Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care

decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	<b>CPR (Cardiopulmonary Resuscitation):</b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

**Part 3 Other instructions, such as hospice care, burial arrangements, etc.:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional pages if necessary)

**Part 4 Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_

No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

\_\_\_\_\_  
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

\_\_\_\_\_  
Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1801 through 68-11-1805.

Chapter 1200-08-24  
Standards for Birthing Centers

Amendments

Rule 1200-08-24-.14 Appendix I is amended by deleting paragraph (2) in its entirety and substituting instead the SS-7037 (July 2014)

following language, so that as amended, the new paragraph shall read:

(2) Advance Directive for Health Care Form

**ADVANCE DIRECTIVE FOR HEALTH CARE\***  
(Tennessee)

**Instructions:** Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	<b>CPR (Cardiopulmonary Resuscitation):</b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	

<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

**Part 3** Other instructions, such as hospice care, burial arrangements, etc.: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional pages if necessary)

**Part 4 Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

- Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_  
 \_\_\_\_\_  
 No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

- I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form. \_\_\_\_\_  
 Signature of witness number 1
- I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form. \_\_\_\_\_  
 Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
 COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_  
 \_\_\_\_\_  
 Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

Chapter 1200-08-25  
Standards for Assisted-Care Living Facilities

Amendments

Rule 1200-08-25-.17 Appendix I is amended by deleting paragraph (2) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

(2) Advance Directive for Health Care Form

**ADVANCE DIRECTIVE FOR HEALTH CARE\***  
(Tennessee)

**Instructions:** Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	

<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	<b>CPR (Cardiopulmonary Resuscitation):</b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

**Part 3** Other instructions, such as hospice care, burial arrangements, etc.: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional pages if necessary)

**Part 4 Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_  
 \_\_\_\_\_  
 No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

\_\_\_\_\_  
 Signature of witness number 1

2. I am a competent adult who is not named as the

\_\_\_\_\_

agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

\_\_\_\_\_  
Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

Chapter 1200-08-26  
Standards for Homecare Organizations Providing Home Health Services

Amendments

Rule 1200-08-26-.15 Appendix I is amended by deleting paragraph (2) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

(2) Advance Directive for Health Care Form

**ADVANCE DIRECTIVE FOR HEALTH CARE\***  
(Tennessee)

**Instructions:** Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	<b>CPR (Cardiopulmonary Resuscitation):</b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

**Part 3 Other instructions, such as hospice care, burial arrangements, etc.:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional pages if necessary)

**Part 4 Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_  
 \_\_\_\_\_

No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form. \_\_\_\_\_  
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form. \_\_\_\_\_  
Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_  
Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

Chapter 1200-08-27  
Standards for Homecare Agencies Providing Hospice Services

Amendments

Rule 1200-08-27-.15 is amended by deleting paragraph (2) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

**ADVANCE DIRECTIVE FOR HEALTH CARE\***  
(Tennessee)

**Instructions:** Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	<b>CPR (Cardiopulmonary Resuscitation):</b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal
Yes	No	

		with a new condition but will not help the main illness.
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

**Part 3** Other instructions, such as hospice care, burial arrangements, etc.: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional pages if necessary)

**Part 4 Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

- Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_  
 No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

- I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form. \_\_\_\_\_  
Signature of witness number 1
- I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form. \_\_\_\_\_  
Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_  
Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

Chapter 1200-08-28  
Standards for HIV Supportive Living Centers

Amendments

Rule 1200-08-28-.15 is amended by deleting paragraph (2) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

(2) Advance Directive for Health Care Form

**ADVANCE DIRECTIVE FOR HEALTH CARE\***  
(Tennessee)

**Instructions:** Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment.

Yes	No	Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
-----	----	---

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	<b>CPR (Cardiopulmonary Resuscitation):</b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

**Part 3** Other instructions, such as hospice care, burial arrangements, etc.: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional pages if necessary)

**Part 4 Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

- Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_  
 \_\_\_\_\_  
 No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

- I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.
- I am a competent adult who is not named as the

\_\_\_\_\_  
 Signature of witness number 1

agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

\_\_\_\_\_  
Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

Chapter 1200-08-32  
Standards for End Stage Renal Dialysis Clinics

Amendments

Rule 1200-08-32-.15 Appendix I is amended by deleting paragraph (2) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

(2) Advance Directive for Health Care Form

**ADVANCE DIRECTIVE FOR HEALTH CARE\***  
(Tennessee)

**Instructions:** Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	<b>CPR (Cardiopulmonary Resuscitation):</b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

**Part 3** Other instructions, such as hospice care, burial arrangements, etc.: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional pages if necessary)

**Part 4 Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_

No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form. \_\_\_\_\_  
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form. \_\_\_\_\_  
Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_  
Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

Chapter 1200-08-34  
Standards for Homecare Agencies Providing Professional Support Services  
Amendments

Rule 1200-08-34-.15 Appendix I is amended by deleting paragraph (2) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

**ADVANCE DIRECTIVE FOR HEALTH CARE\***  
(Tennessee)

**Instructions:** Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	<b>CPR (Cardiopulmonary Resuscitation):</b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal
Yes	No	

		with a new condition but will not help the main illness.
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

**Part 3** Other instructions, such as hospice care, burial arrangements, etc.: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional pages if necessary)

**Part 4 Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

- Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_  
 \_\_\_\_\_  
 No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form. \_\_\_\_\_  
 Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form. \_\_\_\_\_  
 Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
 COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_  
 \_\_\_\_\_  
 Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

Chapter 1200-08-35  
Standard for Outpatient Diagnostic Centers

Amendments

Rule 1200-08-35-.15 Appendix I is amended by deleting paragraph (2) in its entirety and by substituting instead the following language, so that as amended, the new paragraph shall read:

(2) Advance Directive for Health Care Form

**ADVANCE DIRECTIVE FOR HEALTH CARE\***  
(Tennessee)

**Instructions:** Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment.

Yes	No	Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
-----	----	---

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked “no” above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking “yes” below, I have indicated treatment I want. By marking “no” below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	<b>CPR (Cardiopulmonary Resuscitation):</b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient’s stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

**Part 3 Other instructions, such as hospice care, burial arrangements, etc.:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional pages if necessary)

**Part 4 Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

- Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_  
 \_\_\_\_\_  
 No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults (“Block A”) **or** by a notary public (“Block B”).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

- I am a competent adult who is not named as the agent. I witnessed the patient’s signature on this form. \_\_\_\_\_  
 Signature of witness number 1
- I am a competent adult who is not named as the \_\_\_\_\_  
 \_\_\_\_\_

agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

\_\_\_\_\_  
Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

Chapter 1200-08-36  
Standards for Adult Care Homes – Level 2

Amendments

Rule 1200-08-36-.18 Appendix I is amended by deleting paragraph (2) in its entirety and substituting instead the following language, so that as amended, the new paragraph shall read:

(2) Advance Directive for Health Care Form

**ADVANCE DIRECTIVE FOR HEALTH CARE\***  
(Tennessee)

**Instructions:** Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, \_\_\_\_\_, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**Part I Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):  I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.  I do not give such permission (this form applies only when I no longer have capacity).

**Part 2 Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "no" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Unconscious Condition:</b> I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Permanent Confusion:</b> I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Dependent in all Activities of Daily Living:</b> I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>End-Stage Illnesses:</b> I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.
Yes	No	

**Indicate Your Wishes for Treatment:** If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "no" below, I have indicated treatment I **do not want**.

<input type="checkbox"/>	<input type="checkbox"/>	<b>CPR (Cardiopulmonary Resuscitation):</b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Life Support / Other Artificial Support:</b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Treatment of New Conditions:</b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Tube feeding/IV fluids:</b> Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.
Yes	No	

**Part 3 Other instructions, such as hospice care, burial arrangements, etc.:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Attach additional pages if necessary)

**Part 4 Organ donation:** Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

Any organ/tissue       My entire body       Only the following organs/tissues: \_\_\_\_\_

No organ/tissue donation

**SIGNATURE**

**Part 5** Your signature must **either** be witnessed by two competent adults (“Block A”) **or** by a notary public (“Block B”).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient)

**Block A** Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient’s signature on this form. \_\_\_\_\_  
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient’s estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient’s signature on this form. \_\_\_\_\_  
Signature of witness number 2

**Block B** You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE  
COUNTY OF \_\_\_\_\_

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the “patient.” The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_  
Signature of Notary Public

**WHAT TO DO WITH THIS ADVANCE DIRECTIVE:** (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; and (4) provide a copy to the person(s) you named as your health care agent.

\* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-11-202, 68-11-204, 68-11-209, 68-11-224, and 68-11-1805.

I certify that the information included in this filing is an accurate and complete representation of the intent and scope of rulemaking proposed by the agency.

Date: 5/3/16

Signature: Kyonte Hughes-Doombs

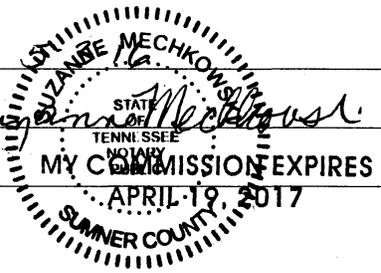
Name of Officer: Kyonte Hughes-Doombs

Title of Officer: Chief Deputy General Counsel  
Department of Health

Subscribed and sworn to before me on: \_\_\_\_\_

Notary Public Signature: Suzanne Mechkowski

My commission expires on: \_\_\_\_\_



**Department of State Use Only**

Filed with the Department of State on: 5/3/16

Tre Hargett

Tre Hargett  
Secretary of State

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