EXHIBIT 1

DECLARATION

I. **Statement of Declarant**

Declaration made this ___________ day of ____________________ 20 ____.
I,____________________, (patient name) being at least 18 years of age and of sound mind, willfully and voluntarily make known my desire that medical treatment as outlined below, including the administration of psychotropic drugs if necessary, be provided to me under the circumstances set forth below, and do hereby declare:

> If at any time I should lapse into a psychotic condition as determined by two physicians who have personally examined me (one of whom is my attending physician) and the physicians have determined that: (i) I am unable to make decisions concerning my medical treatment; (ii) without medical treatment my condition will result in my being gravely disabled and in my posing a serious danger to myself or to others; (iii) medical treatment would serve to remedy the condition and prevent potential for further harm to myself or to others, then I direct that the following personal medical treatment plan, including the elements checked below, be provided to me and be carried out:

___________ Psychotropic drugs ______________________________________;
(please specify)
___________ Hospitalization if necessary;
___________ Counseling;
___________ Therapy involving my family members or friends; and
___________ Other treatment ____
(please specify)

In the absence of my ability to give directions regarding the provision of medical treatment, it is my intention that this Declaration be honored by my family and physician(s) as my legal informed consent to receive medical treatment.

My instructions must prevail even if they create a conflict with the desires of my relatives. This Declaration controls all circumstances.

I understand the full import of this Declaration and declare that I am emotionally and mentally competent at this time to make this Declaration.

Patient's Signature: ____

Address: ____

____

II. **Statement of Witnesses**

I am at least 18 years of age and am not related to the Declarant by blood, marriage or adoption. I further represent that I am not the Declarant's attending physician, an employee of the Declarant's attending physician or an employee of the health care facility in which the Declarant is a patient at this time of execution.

The Declarant is personally known to me and I believe the Declarant to be of sound mind at the time of execution of this Declaration.

Witness Signature: ____

Address: ____

____

Witness Signature: ____

Address: ____

____

III. **Notarization**

Subscribed, sworn to and acknowledged before me by __________________________,

the Declarant, and subscribed and sworn to before me by _______________________

and_____________________________, witnesses, this ______ day of

__________, 20___.

(seal) Signed: ____

____
(official capacity of officer)

EXHIBIT 2

PHYSICIAN CERTIFICATION OF CONDITION SPECIFIED IN DECLARATION

I certify that, in my professional opinion ______________________________________ lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his/her health care and thus is not able to participate in decisions concerning medical treatment to be administered as a result of the following psychotic condition:

____

(specify diagnosis)

According to the Declaration dated _________________________, the patient wishes to receive medical treatment according to the personal medical treatment plan specified in the Declaration under these circumstances, a copy of which is attached to this certification.

____ ________________________

Attending Physician Date

____ ________________________

Second Attending Physician (if available) Date