

# **SOUTH CAROLINA**

## **Advance Directive**

### **Planning for Important Healthcare Decisions**

Courtesy of CaringInfo

[www.caringinfo.org](http://www.caringinfo.org)

CaringInfo, a program of the National Alliance for Care at Home (the Alliance), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

#### **BEFORE YOU BEGIN**

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

#### **ACTION STEPS**

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

## **INTRODUCTION TO YOUR SOUTH CAROLINA ADVANCE HEALTH CARE DIRECTIVE**

This packet contains two legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may complete either, or both, depending on your advance-planning needs.

**South Carolina Health Care Power of Attorney.** This document lets you name an adult, your “agent,” to make decisions about your health care—including decisions about life-sustaining procedures—if you can no longer speak for yourself. The health care power of attorney is especially useful because it appoints someone to speak for you any time you are unable to make your own health care decisions, not only at the end of life.

**South Carolina Declaration of a Desire for a Natural Death,** or Declaration, is your state’s living will. Your declaration lets you state your wishes about health care in the event that you can no longer make your own health care decisions and you are terminally ill or in a persistent vegetative state.

### **How do I make my South Carolina Advance Health Care Directive legal?**

In order to make your **South Carolina Health Care Power of Attorney** legal, you must sign and date it or acknowledge your signature in the presence of two witnesses. Although it is not required, we also recommend having it notarized. Your witnesses cannot be:

- your agent or alternate agent;
- related to you by blood, marriage, or adoption;
- your attending physician or an employee of your attending physician;
- directly financially responsible for your medical care;
- entitled to any portion of your estate after your death either under a will or by operation of law;
- a beneficiary of your life insurance policy; or
- anyone with a claim against your estate upon your death.

In addition, at least one of your witnesses must **not** be an employee of a health facility in which you are a patient.

If you are unable to sign, you may direct someone to sign on your behalf and in your presence.

In order to make your **South Carolina Declaration of a Desire for a Natural Death** legal, you must sign it in the presence of two witnesses **and** have it notarized. Your notary may act as one of your witnesses. These witnesses **cannot** be:

- related to you by blood, marriage, or adoption;
- your attending physician or an employee of your attending physician;

- directly financially responsible for your medical care;
- entitled to any portion of your estate after your death either under a will or by operation of law;
- a beneficiary of your life insurance policy; or
- anyone with a claim against your estate upon your death.

In addition, at least one of your witnesses must **not** be an employee of a health facility in which you are a patient. Finally, if you are a resident in a hospital or nursing facility, one of the witnesses must be an ombudsman designated by the State Ombudsman, Office of the Governor.

### **Whom should I appoint as my agent?**

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

Your agent must be at least 18 and **cannot** be:

- a health care provider, or an employee of a provider, with whom the you have a provider-patient relationship, or
- an employee of a nursing care facility in which the principal resides, or
- a spouse of the health care provider or employee.

You may appoint one of the people above as your agent if he or she is your relative.

You can appoint a second person as your alternate agent. An alternate agent will step in if the person you name as agent is unable, unwilling, or unavailable to act for you.

### **Should I add personal instructions to my advance directive?**

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

If you complete both documents included in this packet, be sure that the instructions you give match. Any agent you appoint in your health care power of attorney is bound by the choices you make in your declaration.

### **When does my agent's authority become effective?**

Your health care power of attorney goes into effect when your doctor, and one other doctor or your agent certify that you are unable to appreciate the nature and implications of your

condition and proposed health care, to make a reasoned decision concerning the proposed health care, or to communicate that decision in an unambiguous manner.

Your living will goes into effect when your doctor and one other doctor certify that you are no longer able to make or communicate your health care decisions and you are terminally ill or in a persistent vegetative state.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

### **Agent Limitations**

No instruction by your agent or in your declaration to withhold or withdraw life-sustaining procedures will be honored in the event you are pregnant and your agent will be bound by the current laws of South Carolina as they regard pregnancy and termination of pregnancies.

### **What if I change my mind?**

You may revoke your health care power of attorney by notifying your health care provider or agent in writing or orally. You can also revoke by executing a new health care power of attorney, if that document states an intention to revoke your earlier health care power of attorney.

You may revoke your declaration by destroying it (or directing someone to destroy it in your presence), by a signed and dated written revocation, by an oral expression to your physician, or by executing a new declaration. You may also appoint an agent in your declaration with the power to revoke it on your behalf.

### **Mental Health Issues**

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

### **What other important facts should I know?**

You may appoint an agent in your declaration. Unlike an agent appointed under your durable power of attorney for health care, an agent appointed through your declaration is only empowered to enforce or revoke your declaration, and may not make other medical treatment decisions.

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate

orders.” DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

**SOUTH CAROLINA HEALTH CARE POWER OF ATTORNEY  
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**HEALTH CARE POWER OF ATTORNEY**

INFORMATION ABOUT THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU NAME AS YOUR AGENT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU CANNOT MAKE THE DECISION FOR YOURSELF. THIS POWER INCLUDES THE POWER TO MAKE DECISIONS ABOUT LIFE-SUSTAINING TREATMENT. UNLESS YOU STATE OTHERWISE, YOUR AGENT WILL HAVE THE SAME AUTHORITY TO MAKE DECISIONS ABOUT YOUR HEALTH CARE AS YOU WOULD HAVE.
2. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENTS OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TREATMENT YOU DO NOT DESIRE OR TREATMENT YOU WANT TO BE SURE YOU RECEIVE. YOUR AGENT WILL BE OBLIGATED TO FOLLOW YOUR INSTRUCTIONS WHEN MAKING DECISIONS ON YOUR BEHALF. YOU MAY ATTACH ADDITIONAL PAGES IF YOU NEED MORE SPACE TO COMPLETE THE STATEMENT.
3. AFTER YOU HAVE SIGNED THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF IF YOU ARE MENTALLY COMPETENT TO DO SO. AFTER YOU HAVE SIGNED THIS DOCUMENT, NO TREATMENT MAY BE GIVEN TO YOU OR STOPPED OVER YOUR OBJECTION IF YOU ARE MENTALLY COMPETENT TO MAKE THAT DECISION.
4. YOU HAVE THE RIGHT TO REVOKE THIS DOCUMENT, AND TERMINATE YOUR AGENT'S AUTHORITY, BY INFORMING EITHER YOUR AGENT OR YOUR HEALTH CARE PROVIDER ORALLY OR IN WRITING.
5. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A SOCIAL WORKER, LAWYER, OR OTHER PERSON TO EXPLAIN IT TO YOU.
6. THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS TWO PERSONS SIGN AS WITNESSES. EACH OF THESE PERSONS MUST EITHER WITNESS YOUR SIGNING OF THE POWER OF ATTORNEY OR WITNESS YOUR ACKNOWLEDGMENT THAT THE SIGNATURE ON THE POWER OF ATTORNEY IS YOURS.

NOTICE

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THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

A. YOUR SPOUSE; YOUR CHILDREN, GRANDCHILDREN, AND OTHER LINEAL DESCENDANTS; YOUR PARENTS, GRANDPARENTS, AND OTHER LINEAL ANCESTORS; YOUR SIBLINGS AND THEIR LINEAL DESCENDANTS; OR A SPOUSE OF ANY OF THESE PERSONS.

B. A PERSON WHO IS DIRECTLY FINANCIALLY RESPONSIBLE FOR YOUR MEDICAL CARE.

C. A PERSON WHO IS NAMED IN YOUR WILL, OR, IF YOU HAVE NO WILL, WHO WOULD INHERIT YOUR PROPERTY BY INTESTATE SUCCESSION.

D. A BENEFICIARY OF A LIFE INSURANCE POLICY ON YOUR LIFE.

E. THE PERSONS NAMED IN THE HEALTH CARE POWER OF ATTORNEY AS YOUR AGENT OR SUCCESSOR AGENT.

F. YOUR PHYSICIAN OR AN EMPLOYEE OF YOUR PHYSICIAN.

G. ANY PERSON WHO WOULD HAVE A CLAIM AGAINST ANY PORTION OF YOUR ESTATE (PERSONS TO WHOM YOU OWE MONEY).

IF YOU ARE A PATIENT IN A HEALTH FACILITY, NO MORE THAN ONE WITNESS MAY BE AN EMPLOYEE OF THAT FACILITY.

7. YOUR AGENT MUST BE A PERSON WHO IS 18 YEARS OLD OR OLDER AND OF SOUND MIND. IT MAY NOT BE YOUR DOCTOR OR ANY OTHER HEALTH CARE PROVIDER THAT IS NOW PROVIDING YOU WITH TREATMENT; OR AN EMPLOYEE OF YOUR DOCTOR OR PROVIDER; OR A SPOUSE OF THE DOCTOR, PROVIDER, OR EMPLOYEE; UNLESS THE PERSON IS A RELATIVE OF YOURS.

8. YOU SHOULD INFORM THE PERSON THAT YOU WANT HIM OR HER TO BE YOUR HEALTH CARE AGENT. YOU SHOULD DISCUSS THIS DOCUMENT WITH YOUR AGENT AND YOUR PHYSICIAN AND GIVE EACH A SIGNED COPY. IF YOU ARE IN A HEALTH CARE FACILITY OR A NURSING CARE FACILITY, A COPY OF THIS DOCUMENT SHOULD BE INCLUDED IN YOUR MEDICAL RECORD.

NOTICE  
(CONTINUED)

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PRINT YOUR NAME

1. DESIGNATION OF HEALTH CARE AGENT

I, \_\_\_\_\_, hereby appoint:  
(Principal)

\_\_\_\_\_  
(Agent's Name)

\_\_\_\_\_  
(Address's Address)

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_ as  
my agent to make health care decisions for me as authorized in this  
document.

2. Successor Agent: If an agent named by me dies, becomes legally  
disabled, resigns, refuses to act, becomes unavailable, or if an agent who is  
my spouse is divorced or separated from me, I name the following as  
successors to my agent, each to act alone and successively, in the order  
named:

a. First Alternate Agent:

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

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

b. Second Alternate Agent:

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

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_

Unavailability of Agent(s): If at any relevant time the agent or successor  
agents named here are unable or unwilling to make decisions concerning my  
health care, and those decisions are to be made by a guardian, by the  
Probate Court, or by a surrogate pursuant to the Adult Health Care Consent  
Act, it is my intention that the guardian, Probate Court, or surrogate make  
those decisions in accordance with my directions as stated in this document.

PRINT THE NAME,  
HOME ADDRESS,  
AND TELEPHONE  
NUMBERS OF YOUR  
AGENT

PRINT THE NAME,  
ADDRESS AND  
TELEPHONE  
NUMBER OF YOUR  
ALTERNATE  
AGENT(S)

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**2. EFFECTIVE DATE AND DURABILITY**

By this document I intend to create a durable power of attorney effective upon, and only during, any period of mental incompetence, except as provided in Paragraph 3 below.

**3. HIPAA AUTHORIZATION**

When considering or making health care decisions for me, all individually identifiable health information and medical records shall be released without restriction to my health care agent(s) and/or my alternate health care agent(s) named above including, but not limited to, (i) diagnostic, treatment, other health care, and related insurance and financial records and information associated with any past, present, or future physical or mental health condition including, but not limited to, diagnosis or treatment of HIV/AIDS, sexually transmitted disease(s), mental illness, and/or drug or alcohol abuse and (ii) any written opinion relating to my health that such health care agent(s) and/or alternate health care agent(s) may have requested. Without limiting the generality of the foregoing, this release authority applies to all health information and medical records governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164; is effective whether or not I am mentally competent; has no expiration date; and shall terminate only in the event that I revoke the authority in writing and deliver it to my health care provider.

**4. AGENT'S POWERS**

I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in this document or otherwise expressed by me or known to my agent. In making any decision, my agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my agent cannot determine the choice I would want made, then my agent shall make a choice for me based upon what my agent believes to be in my best interests. My agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below.

AGENT'S POWERS



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ORGAN DONATION

INITIAL TO  
INDICATE  
WHETHER YOU  
WANT YOUR AGENT  
TO BE ABLE TO  
DONATE YOUR  
ORGANS

5. ORGAN DONATION (INITIAL ONLY ONE)

My agent may \_\_\_; may not \_\_\_ consent to the donation of all or any of my tissue or organs for purposes of transplantation.

6. EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH (LIVING WILL)

I understand that if I have a valid Declaration of a Desire for a Natural Death, the instructions contained in the Declaration will be given effect in any situation to which they are applicable. My agent will have authority to make decisions concerning my health care only in situations to which the Declaration does not apply.

7. STATEMENT OF DESIRES CONCERNING LIFE SUSTAINING TREATMENT

With respect to any Life-Sustaining Treatment, I direct the following:

(INITIAL ONLY ONE OF THE FOLLOWING 3 PARAGRAPHS)

(1) \_\_\_ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

OR

(2) \_\_\_ DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment:

a. if I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time; or

b. if I am in a state of permanent unconsciousness.

OR

(3) \_\_\_ DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

INITIAL ONLY ONE

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**8. STATEMENT OF DESIRES REGARDING TUBE FEEDING**

With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that in situations where life sustaining treatment is being withheld or withdrawn pursuant to Item 7,

(INITIAL ONLY ONE OF THE FOLLOWING THREE PARAGRAPHS)

(A) \_\_\_ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged by tube feeding if my agent believes the burdens of tube feeding outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved, and the quality as well as the possible extension of my life in making this decision.

OR

(B) \_\_\_ DIRECTIVE TO WITHHOLD OR WITHDRAW TUBE FEEDING. I do not want my life prolonged by tube feeding.

OR

(C) \_\_\_ DIRECTIVE FOR PROVISION OF TUBE FEEDING. I want tube feeding to be provided within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedure, and without regard to whether other forms of life-sustaining treatment are being withheld or withdrawn.

IF YOU DO NOT INITIAL ANY OF THE STATEMENTS IN PARAGRAPH 8, YOUR AGENT WILL NOT HAVE AUTHORITY TO DIRECT THAT NUTRITION AND HYDRATION NECESSARY FOR COMFORT CARE OR ALLEVIATION OF PAIN BE WITHDRAWN.

INITIAL ONLY ONE



**SOUTH CAROLINA HEALTH CARE POWER OF ATTORNEY**  
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DATE AND PRINT  
YOUR ADDRESS

SIGN AND PRINT  
YOUR NAME

WITNESSES MUST  
SIGN, DATE, AND  
PRINT THEIR  
TELEPHONE  
NUMBERS AND  
ADDRESSES HERE

A NOTARY  
PUBLIC MAY  
COMPLETE THIS  
PORTION OF THE  
FORM, BUT IT IS  
NOT REQUIRED

© 2005 National  
Alliance for Care  
at Home. 2025  
Revised.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Health Care Power of Attorney on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. My current home address is:

Principal's Signature: \_\_\_\_\_

Print Name of Principal: \_\_\_\_\_

**WITNESS STATEMENT**

I declare, on the basis of information and belief, that the person who signed or acknowledged this document (the principal) is personally known to me, that he/she signed or acknowledged this Health Care Power of Attorney in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not related to the principal by blood, marriage, or adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them. I am not directly financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of an insurance policy on the principal's life, nor do I have a claim against the principal's estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health facility in which the principal is a patient. I am not appointed as Health Care Agent or Successor Health Care Agent by this document.

Witness No. 1

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

Witness No. 2

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

STATE OF SOUTH CAROLINA  
COUNTY OF \_\_\_\_\_

The foregoing instrument was acknowledged before me by Principal on

\_\_\_\_\_, 20\_\_\_\_\_.

Notary Public for South Carolina

My Commission Expires: \_\_\_\_\_

Courtesy of CaringInfo  
[www.caringinfo.org](http://www.caringinfo.org)

**DECLARATION OF A DESIRE FOR A NATURAL DEATH**

STATE OF SOUTH CAROLINA

COUNTY OF \_\_\_\_\_

PRINT NAME,  
ADDRESS, AND  
DATE

I, \_\_\_\_\_ (print your name), Declarant, being at least eighteen years of age and a resident of and domiciled in the City of \_\_\_\_\_, County of \_\_\_\_\_, State of South Carolina, make this Declaration this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

I willfully and voluntarily make known my desire that no life-sustaining procedures be used to prolong my dying if my condition is terminal or if I am in a state of permanent unconsciousness, and I declare:

If at any time I have a condition certified to be a terminal condition by two physicians who have personally examined me, one of whom is my attending physician, and the physicians have determined that my death could occur within a reasonably short period of time without the use of life-sustaining procedures or if the physicians certify that I am in a state of permanent unconsciousness and where the application of life-sustaining procedures would serve only to prolong the dying process, I direct that the procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure necessary to provide me with comfort care.

**INSTRUCTIONS CONCERNING ARTIFICIAL NUTRITION AND HYDRATION**

**INITIAL ONE OF THE FOLLOWING STATEMENTS**

If my condition is terminal and could result in death within a reasonably short time,

\_\_\_\_\_ I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

\_\_\_\_\_ I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

**INITIAL ONE OF THE FOLLOWING STATEMENTS**

If I am in a persistent vegetative state or other condition of permanent unconsciousness,

\_\_\_\_\_ I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

\_\_\_\_\_ I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

INITIAL ONLY ONE

INITIAL ONLY ONE



REVOCATION PROCEDURES

THIS DECLARATION MAY BE REVOKED BY ANY ONE OF THE FOLLOWING METHODS. HOWEVER, A REVOCATION IS NOT EFFECTIVE UNTIL IT IS COMMUNICATED TO THE ATTENDING PHYSICIAN.

(1) BY BEING DEFACED, TORN, OBLITERATED, OR OTHERWISE DESTROYED, IN EXPRESSION OF YOUR INTENT TO REVOKE, BY YOU OR BY SOME PERSON IN YOUR PRESENCE AND BY YOUR DIRECTION. REVOCATION BY DESTRUCTION OF ONE OR MORE OF MULTIPLE

THE ORIGINAL DECLARATIONS;

(2) BY A WRITTEN REVOCATION SIGNED AND DATED BY YOU EXPRESSING YOUR INTENT TO REVOKE;

(3) BY YOUR ORAL EXPRESSION OF YOUR INTENT TO REVOKE THE DECLARATION. AN ORAL REVOCATION COMMUNICATED TO THE ATTENDING PHYSICIAN BY A PERSON OTHER THAN YOU IS EFFECTIVE ONLY IF:

(a) THE PERSON WAS PRESENT WHEN THE ORAL REVOCATION WAS MADE;

(b) THE REVOCATION WAS COMMUNICATED TO THE PHYSICIAN WITHIN A REASONABLE TIME;

(c) YOUR PHYSICAL OR MENTAL CONDITION MAKES IT IMPOSSIBLE FOR THE PHYSICIAN TO CONFIRM THROUGH SUBSEQUENT CONVERSATION WITH YOU THAT THE REVOCATION HAS OCCURRED.

TO BE EFFECTIVE AS A REVOCATION, THE ORAL EXPRESSION CLEARLY MUST INDICATE YOUR DESIRE THAT THE DECLARATION NOT BE GIVEN EFFECT OR THAT LIFE-SUSTAINING PROCEDURES BE ADMINISTERED;

(4) IF YOU, IN THE SPACE ABOVE, HAVE AUTHORIZED AN AGENT TO REVOKE THE DECLARATION, THE AGENT MAY REVOKE ORALLY OR BY A WRITTEN, SIGNED, AND DATED INSTRUMENT. AN AGENT MAY REVOKE ONLY IF YOU ARE INCOMPETENT TO DO SO. AN AGENT MAY REVOKE THE DECLARATION PERMANENTLY OR TEMPORARILY.

(5) BY YOUR EXECUTING ANOTHER DECLARATION AT A LATER TIME.

REVOCATION

**SOUTH CAROLINA DECLARATION — PAGE 4 OF 4**

SIGN AND DATE

\_\_\_\_\_  
Signature of Declarant

\_\_\_\_\_  
Date

**WITNESS AFFIDAVIT**

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

We, \_\_\_\_\_ and \_\_\_\_\_, the undersigned witnesses to the foregoing Declaration, dated the \_\_\_ day of \_\_\_\_\_, 20\_\_\_, at least one of us being first duly sworn, declare to the undersigned authority, on the basis of our best information and belief, that the Declaration was on that date signed by the declarant as and for his DECLARATION OF A DESIRE FOR A NATURAL DEATH in our presence and we, at his request and in his presence, and in the presence of each other, subscribe our names as witnesses on that date. The declarant is personally known to us, and we believe him to be of sound mind. Each of us affirms that he is qualified as a witness to this Declaration under the provisions of the South Carolina Death With Dignity Act in that he is not related to the declarant by blood, marriage, or adoption, either as a spouse, lineal ancestor, descendant of the parents of the declarant, or spouse of any of them; nor directly financially responsible for the declarant's medical care; nor entitled to any portion of the declarant's estate upon his decease, whether under any will or as an heir by intestate succession; nor the beneficiary of a life insurance policy of the declarant; nor the declarant's attending physician; nor an employee of the attending physician; nor a person who has a claim against the declarant's decedent's estate as of this time. No more than one of us is an employee of a health facility in which the declarant is a patient. If the declarant is a resident in a hospital or nursing care facility at the date of execution of this Declaration, at least one of us is an ombudsman designated by the State Ombudsman, Office of the Governor.

WITNESSES SIGN  
HERE

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Subscribed before me by \_\_\_\_\_, the declarant, and subscribed and sworn to before me by \_\_\_\_\_, the witnesses, this \_\_\_ day of \_\_\_\_\_, 20\_\_\_.

\_\_\_\_\_  
Signature

Notary Public for \_\_\_\_\_

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

A NOTARY MUST  
COMPLETE THIS  
PORTION OF THE  
FORM

© 2005 National  
Alliance for Care  
at Home. 2025  
Revised.

Courtesy of CaringInfo  
www.caringinfo.org