Okeene Municipal Hospital
Quality Care, Close to Home

# ADVANCE DIRECTIVE ACKNOWLEDGEMENT

Name: _____
(First) (Last) (Middle Initial)

Social Security #:_____ Date of Birth:_____

PLEASE READ THE FOLLOWING FOUR STATEMENTS
**Place your initials after each statement.**

1. I have been given written materials, about my right to accept or refuse medical treatments. _____ (Initial)

2. I have been informed of my rights to declare/formulate "Advance Directives." _____(Initial)

3. I understand that I am not required to have an "Advance Directive" in order to receive medical treatment at the Okeene Municipal Hospital. _____ (Initial)

4. I understand that the terms of any Advance Directive that I have executed will be followed by the health care facility and caregivers to the extent permitted by law. _____ (Initial)

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

❑ I HAVE executed an Advance Directive.

❑ I HAVE NOT executed an Advance Directive.

Signed:_____ Date:_____

Witness:_____ Date:_____