ADVANCE DIRECTIVE
ACKNOWLEDGMENT

NAME : _____ SOC. SEC. NO : _____

IDENTIFICATION NO : _____ 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. _____ (Initialed)

2. I have been informed of my rights to formulate Advance Directives. _____ (Initialed)

3. I understand that I am not required to have an Advance Directive in order to receive medical treatment at this health care facility. _____ (Initialed)

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

PLEASE CHECK *ONE* OF THE FOLLOWING STATEMENTS:

☐ **I HAVE** executed an Advance Directive.

☐ **I HAVE NOT** executed an Advance Directive.

Signed _____ Date : _____

Witness: _____ Date : _____

Witness: _____ Date : _____

SNF – 8013-B (2/92) SNF FORMS — P.O. Box 4390 Garden Grove, CA 92642 –