Oral Advance Directive

Selection of Health Care Agent

Patient's Name: ______________________________

Patient's Date of Birth: ______________________________

Appointment of a Health Care Agent:

Name: ______________________________

Relationship to patient: ______________________________

Contact: ______________________________

Witnesses to the Oral Advance Directive:
I certify that the patient verbally expressed the above wishes in my presence concerning her health care agent.

Name of Provider: ______________________________

Signature: ______________________ Date: ______________

Name of Provider: ______________________________

Signature: ______________________ Date: ______________

* One witness must be a physician, nurse practitioner, or physician assistant.
* Anyone selected as a health care agent may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant's death.
* Maryland law does not require this document to be notarized.

MedStar Montgomery
Medical Center