DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES REGARDING COVID19 or VARIANTS THEREOF AND TREATMENT PROTOCOLS

DIRECTIVE

I,	, recognize that the best health care is based upon a
partn	ership of trust and communication with my physician. My physician and I will make health
	or treatment decisions together as long as I am of sound mind and able to make my wishes
	n. If there comes a time that I am unable to make medical decisions about myself because
of ill	ness or injury, I direct that the following treatment preferences be honored:
	_ If I am diagnosed with COVID 19, a variant or afflicted with an ailment derived thereof,
	either determined through testing positive or am determined to be presumptively positive
	as defined by my symptoms. I intentionally and specifically reject the use of Remdesivir
	or the use of a ventilator as a treatment option or any other treatment method that is being
	utilized that is resulting in a high injury or death rate.
	_ If treatment is necessary because I have received the COVID19 or any subsequent variant
	vaccine, I hereby revoke traditional treatment and direct my agent to seek alternative
	treatment by professionals treating patients and side effects caused by the vaccine.
	If the facility does not allow for the use of any alternative medical treatments, I direct my
	agent to have me discharged and placed on HOSPICE CARE as opposed to being treated
	with the ventilator or Remdesivir. If I am discharged, I direct that I be provided oxygen
	and any other necessary equipment for comfort.
	I do not consent to receiving any vaccine for COVID19 while be admitted to any medical
	or psychiatric facility.
	or psychiatric facility.
	In the event that new medications or treatment options for COVID19 are made available.
	I direct my Medical Power of Attorney or surrogate to conduct an independent evaluation
	regarding the side effects or risks associated with any new medications or treatment
	options prior to consenting to the administration.

If a medical professional disregards my wishes and refuses to cooperate, I specifically request that a criminal referral be made for assault on my person, false imprisonment and negligent homicide if I should pass away. I have educated myself on the COVID19 pandemic and am aware that the government protocols are life threatening and that the medical establishment is knowingly causing harm.

If the person named as agent in my Medical Power of Attorney is not available, or if I

have not designated a spokesperson, I understand that a spokesperson will be chosen for me following standards specified by law if applicable. If, in the judgment of my physician, my death is imminent within minutes to hours, even with the use of all available medical treatment provided within the prevailing standard of care, I acknowledge that all treatments may be withheld or removed except those needed to maintain my comfort. I specifically direct my spokesperson to seek alternative treatments (like those offered as alternative protocols including Ivermectin and Hydroxychloroquine) I understand that under law this directive may have no effect if I have been diagnosed as pregnant. This directive will remain in effect until I revoke it. No other person may do so.

My residence address is	·	
SIGNED on, 2021.		
		, Declarant
STATE OF	§ § §	
BEFORE ME, the undersigned, known to me to be foregoing instrument in her capacity, and,	d authority, on this day pe e the Declarant whose name is	s subscribed to the
	presence that said instrument is ling COVID 19 or any variants the	her/his Directive to hereof, and that she/
	, Decl	arant
SUBSCRIBED AND ACKNOWI, on this the day	•	the said Declarant,

Notary Public, State of		