INTRODUCTION TO DYING, DEATH, AND BEREAVEMENT FORMS

The meeting can offer assistance around the process of death. The individual may ask the meeting for any level of assistance or none at all. It is very difficult for us to face the prospect of our own death so there may be reluctance to fill out these forms even if we would like the meeting to be involved. It is suggested that the meeting periodically bring Friends together to discuss end-of-life issues and to give Friends a chance to ask questions about the forms and to fill out the parts they find useful. The completed forms are retained by the meeting recorder, until such time as they are needed. It may happen that a Friend may not get around to filling out the forms until death is imminent. If a member of the meeting community is dying, it would be appropriate for someone from the meeting to make clear to the dying person what assistance the meeting can provide. The meeting recorder is responsible for having blank copies of these forms available to anyone in the meeting. Forms may also be available for downloading from the Southeastern Yearly Meeting website <www.seym.org>.

It is recommended that Friends prepare a Will, a Living Will, Designation of Health Care Surrogate, a Durable Power of Attorney, and a Living Trust. Such legal documents, of course, are drawn up with regard to the laws of the state the individual lives in. Instructions and sample forms are available at your local Hospice office and at Aging with Dignity, P.O. Box 1661, Tallahassee, Florida 32302-1661, 1-888-594-7437, <www.agingwithdignity.org>. The Advanced Directives from Aging with Dignity are called Five Wishes.

It would be well for meetings to note that the laws and customs in the end-of-life area are constantly changing. These forms are as good as we can make them now, but changes are bound to occur. Individuals are encouraged to file a Living Will with their primary care doctor and their hospital and verify that the doctor and hospital will follow it.

Legal resources within SEYM are available for those Gay, Lesbian, Bi-sexual, Transgender and Queer persons who face special problems in preparing for their death.

REQUESTS REGARDING MY POSSIBLE INCAPACITY

Name _______________________________________ Date filled out ____________________

Address ____

Phone ____________________________ E-mail ____________________________________

I request ____________________ Monthly Meeting to do the following things for me if I become incapacitated.

1. To notify these persons of my incapacity. Yes _____ No _____

   If yes, **Attach a List** including: name, address, phone number, e-mail, and relationship.

2. To notify my health care surrogate and the person who has a durable power of attorney for my financial affairs. Yes _____ No _____

   If yes, **Attach a List** including: name, address, phone number, e-mail, function and relationship.

3. I have a Living Will? Yes _____ No _____

   If yes, what is the location of the document? **Attach Instructions.**

________________________ ___________ __________ __________ __________

Signature of person making request Date Dates reviewed

Received for ______________________________ Monthly Meeting Date_______________

Clerk or Recorder's Signature _______________________________ Date_______________

REQUESTS REGARDING MY DEATH

Name ______________________________________ Date filled out ____________________

Address ____

Phone ___________________________ E-mail ___________________________________

I request _____________________ Monthly Meeting to do the following things for me at the time of my death.

1. To notify these persons at the time of my death. Yes _____ No _____

   If yes, **Attach a List** including: name, address, phone number, e-mail, and relationship. You may include the executor of your will if you wish.

2. If I have minor children or other dependents and there is no surviving parent or guardian, I ask the meeting to notify those responsible for their care. Yes _____ No _____

   If yes, **Attach a List** with the necessary information.

3. To oversee the disposal of my body in the manner I request. Yes _____ No _____

   If yes, complete, sign and attach the corresponding form provided in this packet, including your financial arrangements to carry this out.

4. To plan and carry out a memorial meeting for me. Yes _____ No _____

   If yes, complete, sign and attach the corresponding form provided in this packet.

5. To provide information, if necessary, for the completion of the Death Certificate. Yes _____ No _____

   If yes, complete, sign and attach the corresponding form provided in this packet.

6. I have a Will and a Living Will? Yes _____ No _____

   If yes, what is the location of these documents? **Attach Instructions**

_________________________ ____________ __________ __________ __________
Signature of person making request Date Dates reviewed

Received for ________________________________ Monthly Meeting Date_______________

Clerk or Recorder's Signature _________________________________ Date_______________

REQUESTS REGARDING DISPOSAL OF MY BODY

Name ____ Date filled out _____________________

Address ____

Phone ____________________________ E-mail _____________________________________

I request ___________________ Monthly Meeting to notify my next of kin/significant other of my wishes for disposal of my body as follows at the time of my death. In the event of no surviving next of kin/significant other, I authorize ___________________ Monthly Meeting to carry out my wishes and have made financial arrangements to do so. **Attach Instructions.**

1. __ Burial __ Cremation __ Medical Research __ Organ Donations ___ Eye Bank
   If you have decided to donate your body to Medical Research, Organ Donations or Eye Bank, please designate a second choice of Burial or Cremation in the event your wishes are unable to be carried out.

2. Do you own a plot for your interment? Cemetery _______________________________________

   City_______________________ State ___________________ Plot ______________________

   Location of deed to cemetery plot ____

3. If your body is to be cremated, what do you wish done with your ashes? Please provide enough detail so that the meeting can carry out your wishes. **Attach Instructions.**

4. If your body is to be given for medical use, who needs to be contacted? **Attach Instructions.**

5. Member of a Memorial Society ____

   Address____ Phone ____________

6. Undertaker preferred ____ Phone ____________

7. Burial insurance company ____

   Policy number ____________________ Location of Policy ____________________________

   If no insurance, expenses are to be met as follows: **Attach Instructions.**

8. Special instructions if death is distant from home: **Attach Instructions.**

_________________________ ___________ _________ _________ _________

Signature of person making request Date Dates reviewed

Received for ________________________________ Monthly Meeting Date_______________

Clerk or Recorder's Signature _________________________________ Date_______________

REQUESTS REGARDING MY MEMORIAL MEETING

Name ____ Date filled out _____________________

Address ____

Phone ______________________________ E-mail ______________________________________

Unless otherwise specified the usual practice would be a memorial meeting for worship as described in the *Faith and Practice* in the Dying, Death , and Bereavement Section. Please indicate any specific requests.

Special requests: ____

____

____

____

____

Flowers accepted? Yes _____ No _____ Where? _______________________________________

In lieu of flowers, contributions may be made to: _______________________________________

____

Do you wish the meeting to put an obituary in the paper? Yes _____ No _____
(Funeral homes will provide a simple notice without extra cost and might offer to submit your obituary for you at the newspaper's rate.)

Do you have an obituary you wish the meeting to use? Yes _____ No _____
Please attach the obituary or information about your life.

___________________________ ____________ __________ __________ __________
Signature of person making request Date Dates reviewed

Received for _________________________________ Monthly Meeting Date_______________

Clerk or Recorder's Signature __________________________________ Date_______________

INFORMATION FORM FOR DEATH CERTIFICATE

Name ____ Date filled out _____________________

Address ____

Phone _____________________________ E-mail _____________________________________

ONLY FILL THIS FORM OUT IF YOU ARE ASKING THE MEETING TO FILE YOUR DEATH CERTIFICATE
Information must agree with legal records and policies

Full legal name ____

Other names on legal documents ____

Address ____

County you live in _________________ Social Security Number ______________________________

Date of Birth ______________________ Birthplace _______________________________________

Citizenship________________________ Present Employer__________________________________

Occupation _______________________ Kind of business or industry __________________________

Marital Status _____________________ Surviving Spouse (Partner) __________________________

Address of surviving spouse (partner) ____

Education _____ 10 – 12, _____ college 1 – 4, _____ college 5 + _____ Race _______________

Father's full name ____

Mother's full name including maiden name____

Surviving children____

Address of surviving children ____

_________________________ ____________ __________ _________ _________
Signature of person making request Date Dates reviewed

Received for ________________________________ Monthly Meeting Date________________

Clerk or Recorder's Signature ____________________________________ Date________________

FORMS FOR MY LIVING WILL

Name ____ Date filled out _____________________

Address ____

Phone ______________________________ E-mail _____________________________________

Included are sample forms for a Living Will and a Designation of Health Care Surrogate, circa 2003. Friends are urged to find current forms applicable to your situation.

Definitions useful in understanding Living Will and Designation of Health Care Surrogate forms.

"Health care decision" means:

A. Informed consent, refusal of consent, or withdrawal of consent to any and all health care, including life-prolonging procedures.
B. The decision to apply for private, public, government, or veterans' benefits to defray the cost of health care.
C. The right of access to all records of the principal that are reasonably necessary for a health care surrogate to make decisions involving health care and to apply for benefits.
D. The decision to make an anatomical gift pursuant to Part X of Chapter 732, Florida Statutes, or the corresponding statutes in other states.

"Incapacity" or "incompetent" means the patient is physically or mentally unable to communicate a willful and knowing health care decision. For the purposes of making an anatomical gift, the term also includes a patient who is deceased.

"Life-prolonging procedure" means any medical procedure, treatment, antibiotics or intervention, including artificially provided sustenance and hydration, or other which sustains, restores, or supplants a spontaneous vital function. The term does not include the administration of medication or performance of a medical procedure, when such medication or procedure is deemed necessary to provide comfort care or to alleviate pain.

"Terminal condition" means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

"End-stage condition" means a condition caused by injury, disease, or illness which has resulted in severe and permanent deterioration, indicated by incapacity and complete physical dependency, and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective.

"Persistent vegetative state" means a permanent and irreversible condition of unconsciousness in which there is:

A. the absence of voluntary action or cognitive behavior or any kind; or
B. an inability to communicate or interact purposefully with the environment.

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SAMPLE – LIVING WILL

Declaration made this _____ day of __________________, 20__,

I, ____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated
And (initial one or more of the following three conditions)

_____________ (initial) I have a terminal condition

or _____________ (initial) I have an end-stage condition

or ____________ (initial) I am in a persistent vegetative state

And if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: ____
Address: ____
____Phone: ____________________

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional): ____
____

Signed: ____Date: ______________________

Witnesses' signature, address, and phone number:
1 . __________________________________ 2. ____________________________________
__________________________________ ____________________________________
__________________________________ ____________________________________

SAMPLE – DESIGNATION OF HEALTH CARE SURROGATE

Name: (Last)________________________(First)_______________________(Middle Initial) ____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: ____
Address: ____
____Phone: ____________________

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: ____
Address: ____
____Phone: ____________________

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law, and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional Instructions (optional): ____
____
____
____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name: ____
Name: ____
Name: ____

Signed: ____Date: ______________________

Witnesses' signature, address, and phone number:
1 . ___________________________________ 2. _____________________________________
___________________________________ _____________________________________
___________________________________ _____________________________________