

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE BILL

No. 1197 Session of
2026

INTRODUCED BY CAPPELLETTI, COSTA, STREET, SCHWANK AND COLLETT,
FEBRUARY 27, 2026

REFERRED TO JUDICIARY, FEBRUARY 27, 2026

AN ACT

1 Amending Title 20 (Decedents, Estates and Fiduciaries) of the
2 Pennsylvania Consolidated Statutes, in health care, repealing
3 provisions relating to pregnancy and further providing for
4 execution, for requirements and options and for example; and
5 making an editorial change.

6 The General Assembly of the Commonwealth of Pennsylvania
7 hereby enacts as follows:

8 Section 1. Section 5429 of Title 20 of the Pennsylvania
9 Consolidated Statutes is repealed:

10 [§ 5429. Pregnancy.

11 (a) Living wills and health care decisions.--Notwithstanding
12 the existence of a living will, a health care decision by a
13 health care representative or health care agent or any other
14 direction to the contrary, life-sustaining treatment, nutrition
15 and hydration shall be provided to a pregnant woman who is
16 incompetent and has an end-stage medical condition or who is
17 permanently unconscious unless, to a reasonable degree of
18 medical certainty as certified on the pregnant woman's medical
19 record by the pregnant woman's attending physician and an

1 obstetrician who has examined the pregnant woman, life-
2 sustaining treatment, nutrition and hydration:

3 (1) will not maintain the pregnant woman in such a way
4 as to permit the continuing development and live birth of the
5 unborn child;

6 (2) will be physically harmful to the pregnant woman; or

7 (3) will cause pain to the pregnant woman that cannot be
8 alleviated by medication.

9 (b) Rule for orders.--Notwithstanding the existence of an
10 order or direction to the contrary, life-sustaining treatment,
11 cardiopulmonary resuscitation, nutrition and hydration shall be
12 provided to a pregnant patient unless, to a reasonable degree of
13 medical certainty as certified on the pregnant patient's medical
14 record by the attending physician and an obstetrician who has
15 examined the pregnant patient, life-sustaining treatment,
16 nutrition and hydration:

17 (1) will not maintain the pregnant patient in such a way
18 as to permit the continuing development and live birth of the
19 unborn child;

20 (2) will be physically harmful to the pregnant patient;
21 or

22 (3) would cause pain to the pregnant patient that cannot
23 be alleviated by medication.

24 (c) Pregnancy test.--Nothing in this chapter shall require a
25 physician to perform a pregnancy test unless the physician has
26 reason to believe that the woman may be pregnant.

27 (d) Payment of expenses by Commonwealth.--

28 (1) In the event that treatment, cardiopulmonary
29 resuscitation, nutrition and hydration are provided to a
30 pregnant woman, notwithstanding the existence of a living

1 will, health care decision by a health care representative or
2 health care agent, order or direction to the contrary, the
3 Commonwealth shall pay all usual, customary and reasonable
4 expenses directly, indirectly and actually incurred by the
5 pregnant woman to whom such treatment, cardiopulmonary
6 resuscitation, nutrition and hydration are provided.

7 (2) The Commonwealth shall have the right of subrogation
8 against all moneys paid by any third-party health insurer on
9 behalf of the pregnant woman.

10 (3) The expenditures incurred on behalf of the pregnant
11 woman constitute a grant, and a lien may not be placed upon
12 the property of the pregnant woman, her estate or her heirs.]

13 Section 2. Section 5442 of Title 20 is amended by adding a
14 subsection to read:

15 § 5442. Execution.

16 * * *

17 (b.1) Optional provision.--A living will may contain a
18 provision expressing the individual's decisions relating to the
19 initiation, continuation, withholding or withdrawal of life-
20 sustaining treatment if the individual is diagnosed as pregnant.

21 * * *

22 Section 3. Section 5453(b) of Title 20 is amended by adding
23 a paragraph to read:

24 § 5453. Requirements and options.

25 * * *

26 (b) Optional provisions.--A health care power of attorney
27 may, but need not:

28 * * *

29 (8) Contain a provision expressing the principal's
30 health care decisions and related actions by the health care

1 agent or health care representative if the principal is
2 diagnosed as pregnant.

3 Section 4. Sections 5456(b) and 5471 of Title 20 are amended
4 to read:

5 § 5456. Authority of health care agent.

6 * * *

7 (b) Life-sustaining treatment decisions.--A life-sustaining
8 treatment decision made by a health care agent is subject to
9 this section and sections [5429 (relating to pregnancy),] 5454
10 (relating to when health care power of attorney operative) and
11 5462(a) (relating to duties of attending physician and health
12 care provider).

13 * * *

14 § 5471. Example.

15 The following is an example of a document that combines a
16 living will and health care power of attorney:

17 DURABLE HEALTH CARE POWER OF ATTORNEY
18 AND HEALTH CARE TREATMENT INSTRUCTIONS

19 (LIVING WILL)

20 PART I

21 INTRODUCTORY REMARKS ON

22 HEALTH CARE DECISION MAKING

23 You have the right to decide the type of health care you
24 want.

25 Should you become unable to understand, make or
26 communicate decisions about medical care, your wishes for
27 medical treatment are most likely to be followed if you
28 express those wishes in advance by:

29 (1) naming a health care agent to decide treatment
30 for you; and

1 (2) giving health care treatment instructions to
2 your health care agent or health care provider.

3 An advance health care directive is a written set of
4 instructions expressing your wishes for medical treatment.

5 NOTICE ABOUT ANATOMICAL DONATION

6 This document may also contain directions regarding
7 whether you wish to donate an organ, tissue or eyes. Under
8 Pennsylvania law, donating a part of the body for
9 transplantation or research is a voluntary act. You do not
10 have to donate an organ, tissue, eye or other part of the
11 body. However, it is important that you make your wishes
12 about anatomical donation known, just as it is important to
13 make your choices about end-of-life care known.

14 Surgeons have made great strides in the field of organ
15 donation and can now transplant hands, facial tissue and
16 limbs. A hand, facial tissue and a limb are examples of what
17 is known as a vascularized composite allograft. Under
18 Pennsylvania law, explicit and specific consent to donate
19 hands, facial tissue, limbs or other vascularized composite
20 allografts must be given. You may use this document to make
21 clear your wish to donate or not to donate hands, facial
22 tissue or limbs.

23 Under Pennsylvania law, the organ donor designation on
24 the driver's license authorizes the individual to donate what
25 we traditionally think of as organs (heart, lung, liver,
26 kidney) and tissue and does not authorize the individual to
27 donate hands, facial tissue, limbs or other vascularized
28 composite allografts.

29 Detailed information about anatomical donation, including
30 the procedure used to recover organs, tissues and eyes, can

1 be found on the Department of Transportation's Internet
2 website. Information about the donation of hands, facial
3 tissue and limbs can also be found on the Department of
4 Transportation's Internet website.

5 You may wish to consult with your physician or your
6 attorney to determine whether the procedure for making an
7 anatomical donation is compatible with fulfilling your
8 specific choices for end-of-life care. In addition, you may
9 want to consult with clergy regarding whether you want to
10 donate an organ, a hand, facial tissue or limb or other part
11 of the body. It is important to understand that donating a
12 hand, limb or facial tissue may have an impact on funeral
13 arrangements and that an open casket may not be possible.

14 An advance health care directive may contain a health
15 care power of attorney, where you name a person called a
16 "health care agent" to decide treatment for you, and a living
17 will, where you tell your health care agent and health care
18 providers your choices regarding the initiation,
19 continuation, withholding or withdrawal of life-sustaining
20 treatment and other specific directions regarding end-of-life
21 care and your views regarding organ and tissue donation.

22 You may limit your health care agent's involvement in
23 deciding your medical treatment so that your health care
24 agent will speak for you only when you are unable to speak
25 for yourself or you may give your health care agent the power
26 to speak for you immediately. This combined form gives your
27 health care agent the power to speak for you only when you
28 are unable to speak for yourself. A living will cannot be
29 followed unless your attending physician determines that you
30 lack the ability to understand, make or communicate health

1 care decisions for yourself and you are either permanently
2 unconscious or you have an end-stage medical condition, which
3 is a condition that will result in death despite the
4 introduction or continuation of medical treatment. You, and
5 not your health care agent, remain responsible for the cost
6 of your medical care.

7 If you do not write down your wishes about your health
8 care in advance, and if later you become unable to
9 understand, make or communicate these decisions, those wishes
10 may not be honored because they may remain unknown to others.

11 A health care provider who refuses to honor your wishes
12 about health care must tell you of its refusal and help to
13 transfer you to a health care provider who will honor your
14 wishes.

15 You should give a copy of your advance health care
16 directive (a living will, health care power of attorney or a
17 document containing both) to your health care agent, your
18 physicians, family members and others whom you expect would
19 likely attend to your needs if you become unable to
20 understand, make or communicate decisions about medical care.
21 If your health care wishes change, tell your physician and
22 write a new advance health care directive to replace your old
23 one. If your wishes about donating an organ, tissue or eyes
24 change, tell your physician and write a new advance health
25 care directive to replace your old one. If you do not wish to
26 donate a hand, facial tissue or limb, it is important to make
27 that clear in your advance health care directive or health
28 care power of attorney, or both. It is important in selecting
29 a health care agent that you choose a person you trust who is
30 likely to be available in a medical situation where you

1 cannot make decisions for yourself. You should inform that
2 person that you have appointed him or her as your health care
3 agent and discuss your beliefs and values with him or her so
4 that your health care agent will understand your health care
5 objectives, including whether you want to limit or withhold
6 life-sustaining measures in the event that you become
7 permanently unconscious or have an end-stage medical
8 condition. You should also tell your health care agent
9 whether you want to donate organs, tissue, eyes or other
10 parts of the body and whether you want to make a donation of
11 your hands, facial tissue or limbs. It is important to
12 understand that if you decide to donate a hand, limb or
13 facial tissue it may impact funeral arrangements and that an
14 open casket may not be possible.

15 You may wish to consult with knowledgeable, trusted
16 individuals such as family members, your physician or clergy
17 when considering an expression of your values and health care
18 wishes. You are free to create your own advance health care
19 directive to convey your wishes regarding medical treatment.
20 The following form is an example of an advance health care
21 directive that combines a health care power of attorney with
22 a living will.

23 NOTES ABOUT THE USE OF THIS FORM

24 If you decide to use this form or create your own advance
25 health care directive, you should consult with your physician
26 and your attorney to make sure that your wishes are clearly
27 expressed and comply with the law.

28 If you decide to use this form but disagree with any of
29 its statements, you may cross out those statements.

30 You may add comments to this form or use your own form to

1 help your physician or health care agent decide your medical
2 care.

3 This form is designed to give your health care agent
4 broad powers to make health care decisions for you whenever
5 you cannot make them for yourself. It is also designed to
6 express a desire to limit or authorize care if you have an
7 end-stage medical condition or are permanently unconscious.
8 If you do not desire to give your health care agent broad
9 powers, or you do not wish to limit your care if you have an
10 end-stage medical condition or are permanently unconscious,
11 you may wish to use a different form or create your own. YOU
12 SHOULD ALSO USE A DIFFERENT FORM IF YOU WISH TO EXPRESS YOUR
13 PREFERENCES IN MORE DETAIL THAN THIS FORM ALLOWS OR IF YOU
14 WISH FOR YOUR HEALTH CARE AGENT TO BE ABLE TO SPEAK FOR YOU
15 IMMEDIATELY. In these situations, it is particularly
16 important that you consult with your attorney and physician
17 to make sure that your wishes are clearly expressed,
18 including whether you want to limit or withhold life-
19 sustaining measures in the event that you become permanently
20 unconscious or have an end-stage medical condition and
21 whether you wish to donate a part of the body for
22 transplantation or research. You should also clearly express
23 whether or not you wish to donate hands, facial tissue or
24 limbs.

25 This form allows you to tell your health care agent your
26 goals if you have an end-stage medical condition or other
27 extreme and irreversible medical condition, such as advanced
28 Alzheimer's disease. Do you want medical care applied
29 aggressively in these situations or would you consider such
30 aggressive medical care burdensome and undesirable?

1 You may choose whether you want your health care agent to
2 be bound by your instructions or whether you want your health
3 care agent to be able to decide at the time what course of
4 treatment the health care agent thinks most fully reflects
5 your wishes and values.

6 [If you are a woman and diagnosed as being pregnant at
7 the time a health care decision would otherwise be made
8 pursuant to this form, the laws of this Commonwealth prohibit
9 implementation of that decision if it directs that life-
10 sustaining treatment, including nutrition and hydration, be
11 withheld or withdrawn from you, unless your attending
12 physician and an obstetrician who have examined you certify
13 in your medical record that the life-sustaining treatment:

14 (1) will not maintain you in such a way as to permit the
15 continuing development and live birth of the unborn child;

16 (2) will be physically harmful to you; or

17 (3) will cause pain to you that cannot be alleviated by
18 medication.

19 A physician is not required to perform a pregnancy test on
20 you unless the physician has reason to believe that you may
21 be pregnant.]

22 Pennsylvania law protects your health care agent and
23 health care providers from any legal liability for following
24 in good faith your wishes as expressed in the form or by your
25 health care agent's direction. It does not otherwise change
26 professional standards or excuse negligence in the way your
27 wishes are carried out. If you have any questions about the
28 law, consult an attorney for guidance.

29 This form and explanation is not intended to take the
30 place of specific legal or medical advice for which you

1 should rely upon your own attorney and physician.

2 PART II

3 DURABLE HEALTH CARE POWER OF ATTORNEY

4 I,, of.....
5 County, Pennsylvania, appoint the person named below to be my
6 health care agent to make health and personal care decisions
7 for me.

8 Effective immediately and continuously until my death or
9 revocation by a writing signed by me or someone authorized to
10 make health care treatment decisions for me, I authorize all
11 health care providers or other covered entities to disclose
12 to my health care agent, upon my agent's request, any
13 information, oral or written, regarding my physical or mental
14 health, including, but not limited to, medical and hospital
15 records and what is otherwise private, privileged, protected
16 or personal health information, such as health information as
17 defined and described in the Health Insurance Portability and
18 Accountability Act of 1996 (Public Law 104-191, 110 Stat.
19 1936), the regulations promulgated thereunder and any other
20 State or local laws and rules. Information disclosed by a
21 health care provider or other covered entity may be
22 redisclosed and may no longer be subject to the privacy rules
23 provided by 45 C.F.R. Pt. 164.

24 The remainder of this document will take effect when and
25 only when I lack the ability to understand, make or
26 communicate a choice regarding a health or personal care
27 decision as verified by my attending physician. My health
28 care agent may not delegate the authority to make decisions.

29 MY HEALTH CARE AGENT HAS ALL OF THE FOLLOWING POWERS
30 SUBJECT TO THE HEALTH CARE TREATMENT INSTRUCTIONS THAT FOLLOW

1 IN PART III (CROSS OUT ANY POWERS YOU DO NOT WANT TO GIVE
2 YOUR HEALTH CARE AGENT):

3 1. To authorize, withhold or withdraw medical care and
4 surgical procedures.

5 2. To authorize, withhold or withdraw nutrition (food)
6 or hydration (water) medically supplied by tube through my
7 nose, stomach, intestines, arteries or veins.

8 3. To authorize my admission to or discharge from a
9 medical, nursing, residential or similar facility and to make
10 agreements for my care and health insurance for my care,
11 including hospice and/or palliative care.

12 4. To hire and fire medical, social service and other
13 support personnel responsible for my care.

14 5. To take any legal action necessary to do what I have
15 directed.

16 6. To request that a physician responsible for my care
17 issue a do-not-resuscitate (DNR) order, including an out-of-
18 hospital DNR order, and sign any required documents and
19 consents.

20 7. To authorize or refuse to authorize donation of what
21 we traditionally think of as organs (for example, heart,
22 lung, liver, kidney), tissue, eyes or other parts of the
23 body.

24 8. To authorize or refuse to authorize donation of
25 hands, facial tissue, limbs or other vascularized composite
26 allografts.

27 APPOINTMENT OF HEALTH CARE AGENT

28 I appoint the following health care agent:

29 Health Care Agent:.....

30 (Name and relationship)

1 Address:.....
2
3 Telephone Number: Home..... Work.....
4 E-mail:.....

5 IF YOU DO NOT NAME A HEALTH CARE AGENT, HEALTH CARE PROVIDERS
6 WILL ASK YOUR FAMILY OR AN ADULT WHO KNOWS YOUR PREFERENCES
7 AND VALUES FOR HELP IN DETERMINING YOUR WISHES FOR TREATMENT.
8 NOTE THAT YOU MAY NOT APPOINT YOUR DOCTOR OR OTHER HEALTH
9 CARE PROVIDER AS YOUR HEALTH CARE AGENT UNLESS RELATED TO YOU
10 BY BLOOD, MARRIAGE OR ADOPTION.

11 If my health care agent is not readily available or if my
12 health care agent is my spouse and an action for divorce
13 is filed by either of us after the date of this document,
14 I appoint the person or persons named below in the order
15 named. (It is helpful, but not required, to name
16 alternative health care agents.)

17 First Alternative Health Care Agent:.....
18 (Name and relationship)

19 Address:.....
20

21 Telephone Number: Home..... Work.....

22 E-mail:.....

23 Second Alternative Health Care Agent:.....
24 (Name and relationship)

25 Address:.....
26

27 Telephone Number: Home..... Work.....

28 E-mail:.....

29 GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL) GOALS

30 If I have an end-stage medical condition or other extreme

1 irreversible medical condition, my goals in making medical
2 decisions are as follows (insert your personal priorities
3 such as comfort, care, preservation of mental function,
4 etc.):.....
5
6
7

8 SEVERE BRAIN DAMAGE OR BRAIN DISEASE

9 If I should suffer from severe and irreversible brain
10 damage or brain disease with no realistic hope of significant
11 recovery, I would consider such a condition intolerable and
12 the application of aggressive medical care to be burdensome.
13 I therefore request that my health care agent respond to any
14 intervening (other and separate) life-threatening conditions
15 in the same manner as directed for an end-stage medical
16 condition or state of permanent unconsciousness as I have
17 indicated below.

18 Initials.....I agree

19 Initials.....I disagree

20 PART III

21 HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT

22 OF END-STAGE MEDICAL CONDITION

23 OR PERMANENT UNCONSCIOUSNESS

24 (LIVING WILL)

25 The following health care treatment instructions exercise
26 my right to make my own health care decisions. These
27 instructions are intended to provide clear and convincing
28 evidence of my wishes to be followed when I lack the capacity
29 to understand, make or communicate my treatment decisions:

30 IF I HAVE AN END-STAGE MEDICAL CONDITION (WHICH WILL

1 RESULT IN MY DEATH, DESPITE THE INTRODUCTION OR CONTINUATION
2 OF MEDICAL TREATMENT) OR AM PERMANENTLY UNCONSCIOUS SUCH AS
3 AN IRREVERSIBLE COMA OR AN IRREVERSIBLE VEGETATIVE STATE AND
4 THERE IS NO REALISTIC HOPE OF SIGNIFICANT RECOVERY, ALL OF
5 THE FOLLOWING APPLY (CROSS OUT ANY TREATMENT INSTRUCTIONS
6 WITH WHICH YOU DO NOT AGREE):

7 1. I direct that I be given health care treatment to
8 relieve pain or provide comfort even if such treatment might
9 shorten my life, suppress my appetite or my breathing, or be
10 habit forming.

11 2. I direct that all life prolonging procedures be
12 withheld or withdrawn. You may want to consult with your
13 physician and attorney in order to determine whether your
14 designated choices regarding end-of-life care are compatible
15 with anatomical donation. In order to donate an organ your
16 body may need to be maintained on artificial support after
17 you have been declared dead to facilitate anatomical
18 donation. Detailed information about the procedure for being
19 declared brain dead or dead by lack of cardiac function and
20 information about organ donation can be found on the
21 Department of Transportation's publicly accessible Internet
22 website.

23 3. I specifically do not want any of the following as
24 life prolonging procedures: (If you wish to receive any of
25 these treatments, write "I do want" after the treatment)

- 26 heart-lung resuscitation (CPR).....
- 27 mechanical ventilator (breathing machine).....
- 28 dialysis (kidney machine).....
- 29 surgery.....
- 30 chemotherapy.....

1 radiation treatment.....

2 antibiotics.....

3 Please indicate whether you want nutrition (food) or
4 hydration (water) medically supplied by a tube into your
5 nose, stomach, intestine, arteries, or veins if you have an
6 end-stage medical condition or are permanently unconscious
7 and there is no realistic hope of significant recovery.

8 (Initial only one statement.)

9 TUBE FEEDINGS

10I want tube feedings to be given

11 OR

12 NO TUBE FEEDINGS

13I do not want tube feedings to be given.

14 4. If I have authorized donation of an organ (such as a
15 heart, liver or lung) or a vascularized composite allograft
16 in the next section of this document, I authorize the use of
17 artificial support, including a ventilator, for a limited
18 period of time after I am declared dead to facilitate the
19 donation.

20 5. I specifically do not want to be on artificial
21 support after I am declared dead.....

22 HEALTH CARE AGENT'S USE OF INSTRUCTIONS

23 (INITIAL ONE OPTION ONLY).

24My health care agent must follow these
25 instructions.

26 OR

27These instructions are only guidance.

28 My health care agent shall have final say and may
29 override any of my instructions. (Indicate any
30 exceptions).....

1
2

3 If I did not appoint a health care agent, these
4 instructions shall be followed.

5 LEGAL PROTECTION

6 Pennsylvania law protects my health care agent and health
7 care providers from any legal liability for their good faith
8 actions in following my wishes as expressed in this form or
9 in complying with my health care agent's direction. On behalf
10 of myself, my executors and heirs, I further hold my health
11 care agent and my health care providers harmless and
12 indemnify them against any claim for their good faith actions
13 in recognizing my health care agent's authority or in
14 following my treatment instructions.

15 SIGNATURE.....

16 INFORMATION ABOUT ANATOMICAL DONATION

17 Donating an organ or other part of the body is a
18 voluntary act. Under Pennsylvania law, you do not have to
19 donate an organ or any other part of your body. It is
20 important to know the effect of organ donation on your
21 decisions about end-of-life care so that your wishes about
22 end-of-life care will be fulfilled. If someone wishes to
23 become an organ donor, the person may be kept on artificial
24 support after the person has been declared dead to facilitate
25 anatomical donation. Detailed information about the procedure
26 for recovering organs and other parts of the body and
27 detailed information about brain death and cardiac death may
28 be found on the Department of Transportation's publicly
29 accessible Internet website.

30 Under Pennsylvania law, the organ donor designation on
the driver's license authorizes the individual to donate what

1 we traditionally think of as organs (for example, heart,
2 lung, liver, kidney) and tissue and does not authorize the
3 individual to donate hands, facial tissue, limbs or other
4 vascularized composite allografts.

5 Under Pennsylvania law, explicit and specific consent to
6 donate hands, facial tissue, limbs and other vascularized
7 composite allografts is needed. Donation of these parts of
8 the body is voluntary. Information about the procedure to
9 transplant hands, facial tissue and limbs can be found on the
10 Department of Transportation's publicly accessible Internet
11 website. It is important to know that donating a hand, limb
12 or facial tissue may impact funeral arrangements and that an
13 open casket may not be possible.

14 ORGAN DONATION

15I consent to making an anatomical gift. This gift
16 does not include hands, facial tissue, limbs or other
17 vascularized composite allografts. I understand that if I
18 want to donate a hand, facial tissue, limb or other
19 vascularized composite allograft, there is another place in
20 this document for me to do so. I also understand the hospital
21 may provide artificial support, which may include a
22 ventilator, after I am declared dead in order to facilitate
23 donation. I consent to making a gift of the following parts
24 of my body for transplantation or research (please insert any
25 limitations you desire on donation of specific organs or
26 tissues or eyes or any limitation on the use of a donated
27 part of the body):

28
29
30

1 SIGNATURE.....DATE.....

2 GIFT OF HANDS, FACIAL TISSUE, LIMBS AND OTHER VASCULARIZED
3 COMPOSITE ALLOGRAFTS

4I consent to making a gift of my hands, facial
5 tissue, limbs or other vascularized composite allografts. I
6 also understand that I have the option of requesting
7 reconstruction of my body in preparation for burial and that
8 anonymity of identity may not be able to be protected in the
9 case of donation of hands, facial tissue or limbs. I also
10 understand that burial arrangements may be affected and that
11 an open casket may not be possible. I also understand that
12 the hospital may provide artificial support, which may
13 include a ventilator, after I am declared dead in order to
14 facilitate donation.

15 Please insert any limitations you desire on donation of
16 hands, facial tissue, limbs or other vascularized composite
17 allografts and whether you request reconstructive surgery
18 before burial:

19
20
21

22 SIGNATURE.....DATE.....

23I do not consent to donating my organs, tissues
24 or any other part of my body, including hands, facial tissue,
25 limbs or other vascularized composite allografts. This
26 provision serves as a refusal to donate any part of my body.
27 This provision also serves as a revocation of any prior
28 decision I have made to donate organs, tissues or other parts
29 of my body, including hands, facial tissue, limbs or other
30 vascularized composite allograft made in a prior document,

1 including a driver's license, will, power of attorney, health
2 care power of attorney or other document.

3 SIGNATURE.....DATE.....

4 Having carefully read this document, I have signed it
5 this.....day of....., 20..., revoking all previous
6 health care powers of attorney and health care treatment
7 instructions.

8

9 (SIGN FULL NAME HERE FOR HEALTH CARE POWER OF ATTORNEY AND
10 HEALTH CARE TREATMENT INSTRUCTIONS)

11 WITNESS:.....

12 WITNESS:.....

13 Two witnesses at least 18 years of age are required by
14 Pennsylvania law and should witness your signature in each
15 other's presence. A person who signs this document on behalf
16 of and at the direction of a principal may not be a witness.
17 (It is preferable if the witnesses are not your heirs, nor
18 your creditors, nor employed by any of your health care
19 providers.)

20 NOTARIZATION (OPTIONAL)

21 (Notarization of document is not required by Pennsylvania
22 law, but if the document is both witnessed and notarized, it
23 is more likely to be honored by the laws of some other
24 states.)

25 On this.....day of, 20..., before me
26 personally appeared the aforesaid declarant and principal, to
27 me known to be the person described in and who executed the
28 foregoing instrument and acknowledged that he/she executed
29 the same as his/her free act and deed.

30 IN WITNESS WHEREOF, I have hereunto set my hand and

1 affixed my official seal in the County of....., State
2 of..... the day and year first above written.

3

4 Notary Public My commission expires

5 Section 5. The Department of Health shall ensure as part of
6 its licensure process that health care providers under its
7 jurisdiction have policies and procedures in place to provide
8 notice of the repeal of 20 Pa.C.S. § 5429 to patients.

9 Section 6. This act shall take effect immediately.