DIRECTIVE TO PHYSICIANS AND FAMILY OR SURROGATES REGARDING COVID-19 or VARIANTS THEREOF AND TREAMENT PROTOCOLS

DIRECTIVE

I, _____, recognize that the best health care is based upon a partnership of trust and communication with my physician. My physician and I will make health care or treatment decisions together as long as I am of sound mind and able to make my wishes known. If there comes a time that I am unable to make medical decisions about myself because of illness 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 COVID-19 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.

____ 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 this _____ day of _____, 20___.

Declarant Signed _____

Declarant Printed Name _____

Acknowledgement Documentation on Page 3

ACKNOWLEDGEMENT DOCUMENTATION

STATE OF TEXAS §
§
COUNTY OF _____ §

BEFORE ME, the undersigned authority, on this day personally appeared _____, known to me to be the Declarant whose name is subscribed to the foregoing instrument in his/her capacity, and, said person being by me duly sworn, the Declarant _____, did in fact declared to me in my presence that said instrument is his/her Directive to Physicians and Family or Surrogates regarding COVID-19 or any variants thereof, and that she/he had willingly and voluntarily made and executed it as his/her free act and deed for the purposes therein expressed.

Declarant Signed _____,

Printed Name of Declarant _____

SUBSCRIBED AND ACKNOWLEDGED BEFORE ME, by the said Declarant, _____, on this _____ day of _____, 20___.

_____

Notary Public, State of _____

My Commission Expires: _____

- - -END - - -