U.S .ADVANCE CARE PLAN REGISTRY

Registration Agreement

Source Code
56106100

Registrant's Identifying Information (Please type or print clearly) **Name:**

First _____ Middle _____ Last _____ Suffix____

Social Security Number: Last 4 Digits Only XX _____ _____ Date of Birth: Month _____ Day _____ Year _____

Address - Primary Residence: Street Address _____ Apt # _____

City _____ State _____ Zip Code _____

Secondary Residence (if any): Street Address _____ Apt # _____

City _____ State _____ Zip Code _____

Phone Number: Home: ( ) _____ Work: ( ) _____ Secondary Residence: ( )_____

Emergency Contact #1: Name: _____ Relationship to Registrant: _____

Address: _____

Telephone Number: Home: ( ) _____ Work/Other: ( ) _____

Emergency Contact #2: Name: _____ Telephone: ( ): _____

I request that the *U.S. Advance Care Plan Registry*, with offices at 523 Westfield Ave., PO Box 2789, Westfield, New Jersey 07091-2789 ("Registry"), electronically store a copy of my attached advance directive (living will and/or health care proxy), and provide a copy of the stored advance directive to any health care provider who requests it in conjunction with providing care to me. A "health care provider" is any hospital, doctor, skilled nursing facility, nursing facility, home health care agency/provider, ambulatory surgery facility, hospice, or any authorized employee of any of the foregoing. My registration is not effective until I receive written confirmation from the Registry, at the address I have provided above. I understand that I can only register through a Registry member Health Care Provider or a Registry Community Partner. The Registry's member Health Care Providers and Community Partners are not owned or operated by the Registry, and they cannot change any terms of this Registration Agreement; any oral changes are not effective.

I. Registration and Certification: I submit the information herein to confirm my identity if a health care provider requests a copy of my advance directive. I certify that this information is correct, and that the attached advance directive is my currently effective advance directive, which was properly executed in accordance with the laws of the state where it was executed. If the attached advance directive is a copy, I certify that it is a true and correct copy of the original document. I agree to immediately notify the Registry, in writing, at the Registry's address listed above, in the event of my revocation of this Registration, or if the attached advance directive or the identifying information herein are changed in any way. I agree immediately to provide the Registry with a copy of new/changed documents. I will indemnify and hold the Registry harmless for any damages resulting from the Registry's reliance on these certifications, or on any inaccurate information I supplied. If I don't notify the Registry in writing and in a timely manner of any changes, the Registry will not be liable for any damages resulting from the transmission of the documents on file to any health care provider.

II. Authorization: I authorize the Registry to send a copy of my advance directive to any health care provider that requests a copy of it, provided the request conforms to the Registry's policies and procedures. The Registry is not authorized to share my personal information with parties other than health care providers (as defined herein). A copy of this Agreement may be used in place of the original document.

III. Limitations on Liability: Registration is free of charge. Registry shall not be liable for the improper transmission/disclosure of my advance directive.

IV. Term: This Agreement shall remain in effect until Registry receives reliable information that the Registrant is deceased, the Registrant requests, in writing, that the Agreement be terminated, or until registration is cancelled pursuant to the Registry's policies and procedures. When the Agreement is terminated, Registry will use best efforts to remove Registrant's advance directive from its files.

I hereby agree to the above terms and certify to the accuracy of the information provided. I am legally capable of executing this registration.

X_____ DATED: _____/_____/_____

Signature of Registrant or Legal Guardian (Guardian must provide proof of authority)

WITNESS STATEMENT: *I declare that the Registrant who signed this document is personally known to me, that he/she signed or acknowledged this document in my presence, and that he/she appears to be of sound mind and under no duress or undue influence.*

Signature: _____ **Print Name:** Sara D. Allshouse DATED: _____/_____/_____

(Witness #1)

Signature: _____ **Print Name:** Jill Frey DATED: _____/_____/_____

(Witness #2)