Give a copy of this legal document to:
- Your family
- Your agent
- Your alternative agent(s)
- Your physician
- Your hospital's records department
- Your clergy

If you do not wish to name an agent (someone to act on your behalf if you are unable) initial here, print your name and Social Security Number, and move on to part III of Advanced Health Care Directive.

If you do wish to name an agent (someone to act on your behalf if you are unable), fill in your Social Security Number, your agent's name date of birth, telephone number and address in the blanks

You are allowed to select an alternate agent, in the event that your primary agent is not available.

List your alternate's name, telephone number and address in the blanks.

List here the name, telephone number and address for your second choice for an agent if you have chosen one.

Durable Power of Attorney for Health Care and Advance Health Care Directive Legal Document

Take a copy of this legal document with you whenever you go to the hospital

Durable Power of Attorney for Health Care and Advanced Health Care Directive
Part 1
Durable Power of Attorney for Health Care

_____ **I DO NOT** wish to name an agent to make health care decisions for me.
(Initial here and go to Part II)

Selection of agent. It is suggested that only one agent be named. However, if more than one agent is named, any one may act individually unless you specify otherwise.

1. I, (print your name) _____

(SS#) _____ (date of birth) _____

appoint (name person) _____

(phone) _____ (address) _____

(city) _____ (state) _____ (zip)_____

as my agent when I am unable to communicate or make decisions regarding my healthcare.

2. Alternate agent. Only an agent named by me may act under this Durable Power of Attorney. If my Agent resigns or is not able or available to make healthcare decisions for me, or if an Agent named by me is divorced from or is my spouse legally separated from me, I appoint the person(s) named below (in order named if more than one.)

First Alternate:

Name_____Telephone_____

Address_____

City_____ State _____ Zip _____

Second Alternate:

Name_____Telephone_____

Address_____

City_____ State _____Zip_____

If you choose to only have one physician, instead of two physicians to determine if you are incapacitated, initial here.

Your agent's power: if you want your agent to be able to withhold or withdraw artificial nutrition and hydration, initial here.

Your agent's power: if you do not want your agent to be able to withhold or withdraw artificial nutrition and hydration, initial here.

3. Effective date and durability.
This Durable Power of Attorney for Health Care is effective when two physicians decide and certify that I am incapacitated and unable to make and communicate healthcare decisions.

_____ If you want ONE physician instead of TWO, to decide whether you are incapacitated, initial here.

4. Agent's power. I grant to my agent full authority to:

A. Give consent to, prohibit or withdraw any type of healthcare, medical care, treatment or procedure, even if death may result;

_____ If you wish to AUTHORIZE your agent to direct a healthcare provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water), initial here.

_____ If you DO NOT WISH TO AUTHORIZE your agent to direct health care providers to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding of food and water), initial here.

B. Make all necessary arrangements for healthcare services on my behalf, and to hire and fire medical personnel responsible for my care;

C. Move me into or out of any healthcare facility (even if against medical advise) to obtain compliance with the decisions of my agent; and

D. Take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any healthcare provider, and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney for Health Care.

5. Agent's financial liability and compensation.
My agent, acting under this Durable Power of Attorney for Health Care, will incur no personal financial liability. My agent shall not be entitled to compensation for service performed under this Durable Power of Attorney for Health Care, but my agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision hereof.

Part II

Advance Health Care Directive

Initial here if you do not wish to make an Advance Health Care Directive Go to Part III

_____If you DO NOT WISH to make an Advance Health Care Directive, initial here and go to Part III.

I make this ADVANCE HEALTH CARE DIRECTIVE to exercise my right to determine the course of my healthcare and to provide clear and convincing proof of my wishes and instructions about my medical treatment.

If I am persistently unconscious or there is no expectation of my recovery from a serious incapacitating or terminal illness or condition, I direct that all of the life-prolonging procedures that have initialed below be WITHHELD OR WITHDRAWN.

Initial here for the following life-prolonging procedures you do not want. Refer to the glossary located at the end of this booklet for further explanations of the procedures.

I WANT THE FOLLOWING LIFE-PROLONGING PROCEDURES TO BE WITHHELD OR WITHDRAWN (I do not want any of the treatment I have initialed):

_____ artificially supplied nutrition and hydration (including feeding tubes of food and water)

_____ surgery or any other invasive procedure

_____ cardiopulmonary resuscitation (CPR to restart my heart or breathing)

_____ medicine to treat infections (antibiotics)

_____ artificial kidney machine (dialysis)

_____ breathing machine (mechanical ventilator/respirator)

_____ chemotherapy (a medical treatment for cancer using drugs)

_____ radiation therapy (a medical treatment for cancer using radiation)

_____ all other "life-prolonging" medical or surgical procedures that merely are intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury

However, if my physician believes that any "life-prolonging" procedures may lead to a significant recovery, I direct my physician to try the treatment for a medically reasonable period of time. If it does not improve my condition, I direct the treatment be withdrawn, even if it shortens my life. Also, I direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment may shorten my life, suppress my appetite or my breathing, or be habit-forming.

On the lines provided, in your own words, describe:

If medical treatment were to help you regain health, explain here what you believe would be an acceptable quality of life (refer to question #12 in "Commonly Asked Questions").

If it is reasonable to expect that medical treatment will aid me in reaching an acceptable "quality of life," I want my physician to try those treatments. My definition of an "acceptable quality of life" is:

_____

_____

_____

_____

_____

_____

_____

If you were wanting to donate your organs initial "yes." If you do not wish to donate your organs initial "no." If you do not wish not to deal with this issue at this time initial "I do not want to address this question now."

If you selected "yes," check the organs to be donated.

I want to donate my organs and tissue, and I realize it may be necessary to maintain my body artificially after my death on a breathing machine (ventilator) until my organs can be removed.

Yes_____ (initial) No_____ (initial) I do not want to address this question now _____ (initial)

If Yes, please indicate which organs you wish donate:

☐ Any needed organs and tissues

Only the following organs and tissues

☐ heart ☐ lungs ☐ bone ☐ eyes ☐ veins

☐ skin ☐ kidneys ☐ liver ☐ heart valves

☐ other_____

Use this section to describe any other medical directions you would like for your agent to know.

My other directions include:

_____

_____

_____

_____

_____

_____

_____

Part III

General Provisions Included in the Advance Health Care Directive and Durable Powers of Attorney for Health Care

Relationship

1. Relationship between Advance Health Care Directive and Durable Power of Attorney for Health Care. If I have executed the Advance Health Care Directive and Durable Power of Attorney for Health Care I encourage my agent to follow my wishes as expressed in the Advanced Health Care Directive in making decisions regarding life-prolonging procedures. However, I have confidence in my agent's ability to make decisions on my best interest, and I authorize my agent to make decisions that are contrary to my Advance Health Care Directive in his or her best judgement. If the Durable Power of Attorney for Health Care is somehow determined to be ineffective, or if my agent is not able to serve, the Advance Health Care directive is intended to be used on its own firm instructions to my health care providers regarding life prolonging procedures.

Your agent cannot be held liable for health-care decisions.

2. Protection of agent and third parties who rely on my Agent. Neither my agent, nor any person who relies in good faith upon any representations by my agent or alternate agent (s) shall be liable to me, my estate, my heirs or assigns for exercising or recognizing the agents authority.

Revoking past Advance Health Care Directive or Durable Power of Attorney for Health Care

3. Revocation of prior Advance Health Care Directive or Durable Power of Attorney for Health Care. I revoke any prior Living Will, Declaration or Advance Health Care Directive executed by me. If I have appointed an agent in a prior Durable Power of Attorney for Health Care, I revoke any healthcare terms contained in the Durable Power of Attorney for Health Care.

Validity

4. Validity. This document is intended to be valid in any jurisdiction in which it is presented. The provision of this document are separable, so that the invalidity of one or more provisions shall not affect any others. A copy of this document shall be valid as the original.

This form should be signed and witnessed in the presence of a notary.

SIGN HERE for Durable Power of Attorney for Health Care and Advance Health Care Directive. Please ask two (2) persons to witness your signature who are not related to you, are not your assigned agents and are not financially connected to your estate.

You must put today's date and year here.

In witness whereof, I have executed this document this_____ day of _____, 20_____.

You must sign the document here.

Signature _____

Your Social Security Number and date of birth should be written here.

Social Security Number _____ Date of Birth_____

The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned is at least eighteen (18) years of age.

This document must be sighed in the presence of two witnesses. These witnesses must be more than 18 years of age, not related to your DPOA, not an agent for you, and not financially connected to your estate.

Witness_____
Address_____
Date_____

Witness_____
Address_____
Date_____

NOTARIZATION

This document must be notarized by a Notary Public. This is where the Notary will sign and seal the document (Durable Power of Attorney for Health Care).

On this _____day of _____, in the year of _____, before me personally appeared in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed. IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal in the County of _____, State of _____, on the date written above.

Notary Public_____
My Commission Expires _____

(Notary seal)