

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. Creation of a Durable Power of Attorney for Health Care.

I, _____ (the "Principal"), Social Security Number _____, currently residing at _____, _____, _____

County, _____, being of sound mind, intend by this document to create a Durable Power of Attorney for Health Care. I am voluntarily executing this Durable Power of Attorney for Health Care. I expect, despite the creation of this Durable Power of Attorney for Health Care, to be fully informed about and to make any health care decisions for myself whenever I am able to do so. I intend this document to become effective only upon, and to remain in effect only during, any period of incapacity or disability during which, in the opinion of my attending physician, I am unable to make or communicate a choice regarding a particular health care decision. For purposes of this document, "health care decision" means an informed health or personal care decision in the exercise of my right to accept, maintain, discontinue or refuse any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition.

2. Designation of Health Care Agent.

If I am unable to make health care decisions for myself, due to my incapacity, I hereby designate the following person to be my health care agent for the purpose of making health care decisions on my behalf:

Health Care Agent: _____

Relationship: _____

Address: _____

Telephone Number: _____ (Home)

_____ (Work)

If my designated health care agent is ever unable or unwilling to do so, I hereby name the following persons (each to act alone and successively in the order named) as my health care agent:

First Alternate Agent: _____

Relationship: _____

Address: _____

Telephone Number: _____ (Home)

_____ (Work)

Second Alternate Agent: _____

Relationship: _____

Address: _____

Telephone Number: _____ (Home)

_____ (Work)

3. General Statement of Authority Granted.

Unless I have specified otherwise in this document, if I ever am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack capacity to manage my health care decisions, as determined by my attending physician in his or her good faith, I instruct my health care provider to obtain the health care decision of my health care agent for all of my health care. I have discussed my desires thoroughly with my health care agent as well as those named as alternates and believe that my health care agent understands my philosophy regarding the health care decisions I would make if I were able to do so. I desire that my wishes be carried out through the authority given to my health care agent under this document and rely upon my health care agent's judgment on my behalf.

My health care agent is instructed that if I am unable, due to my incapacity, to make a health care decision, my health care agent shall make a health care decision for me. My health care agent shall base the health care decision on any health care choices that I have expressed prior to the time of the decision and shall consider the recommendation of my attending physician, the decision that my health care agent believes to be in my best interest, and the decision that I would make if I had decisional capacity, as best known to my health care agent. My health care agent's authority to interpret my desires is intended to be as broad as possible except for any limitation stated in this document, but shall always be made in accordance with accepted medical practice and upon consideration of the totality of circumstances as then exist.

4. Admission to Nursing or Long-Term Care Facility.

My health care agent may admit me to a nursing facility or other long-term care facility as my health care agent may deem appropriate.

5. Health Care Decision.

It is my desire that my dying shall not be artificially prolonged subject to the following:

- A. If I should have an injury, disease or illness regarded by my physician as incurable and terminal, and if my physician determines that the use or application of life-sustaining procedures (excluding those set forth in B. below) would serve only to artificially prolong the process of my death, I direct that such procedures be withheld and withdrawn and that I be permitted to die naturally and with dignity. In that event, I direct that drugs and medication be administered to me only for the relief of pain and not to prolong my life, even if these pain-killing drugs or medications may hasten my death.
- B. My direction concerning my health care agent's authority to withhold or withdraw non-orally ingested nutrition and hydration (includes nutrition and hydration supplied through tubes entering anywhere in my body) is as follows (INITIAL ONLY ONE OF THE DIRECTIONS BELOW):

_____ (initials) My health care agent shall make all such decisions regarding the withholding or withdrawal of non-orally ingested nutrition hydration in consultation with my physician and considering the totality of my circumstances at the time the decision is to be made.

_____ (initials) I authorize my health care agent to withhold or withdraw non-orally ingested nutrition and hydration only if it is not necessary for my comfort care or the relief of pain and if one of the following additional conditions exists:

My attending physician reasonably believes that my death will occur within approximately fourteen days; or

Non-orally ingested nutrition and hydration cannot be physically assimilated by me; or

The burden of providing non-orally ingested nutrition and hydration outweighs its benefit, provided that the determination of burden refers to the provision of non-orally ingested nutrition and hydration itself and not to the quality of my continued life.

_____ (initials) My health care agent does not have authority to withhold or withdraw non-orally ingested nutrition and hydration.

6. Organ Donation -After Death. (INITIAL ONE OF THE FOLLOWING BELOW)

A. _____ (initials) In the event of my death, I would like to donate my organs for transplantation. I understand that to become an organ donor, I must be declared brain dead and my organ function maintained artificially on a breathing machine (i.e., artificial ventilation) so that my organs can be removed for transplantation. I also understand that, upon my death, my health care agent and/or my next-of-kin will be asked permission for this donation. Therefore, it is in my best interest to inform my health care agent and my next-of-kin about my decision ahead of time and to ask them to honor my request.

B. _____ (initials) wish to donate the following organs and no others:

C. _____ (initials) I do not wish to become an organ donor after my death.

7. Statement of Desires Special Provisions or Limitations.

In exercising authority under this document, my health care agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify below:

8. Authorizations to Agent.

Subject to any limitations in this document, my health care agent shall have the following powers and authorities:

A. To authorize, withhold or withdraw authorization for any and all types of medical care, treatment, surgical and diagnostic procedures, medication and the use of mechanical or other procedures that affect any bodily function, including (but not limited to) artificial respiration, cardiopulmonary resuscitation and non-orally ingested nutrition and hydration, subject to the directions set forth in paragraphs 5.B and 7 above.

B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death.

C. To retain and discharge medical, social service and other support personnel responsible for my care.

D. To authorize my admission to a medical, hospice, nursing, residential care, assisted living or similar facility and to enter into agreement for my care.

- E. To arrange for my discharge, transfer from or change in type of care provided, even against medical advice.
- F. To arrange and contract on my behalf for any health care related service or facility as may be required for my proper care and treatment, without my health care agent incurring personal financial liability therefore.
- G. To make claim for and to commence such legal proceedings as may be necessary and appropriate to recover the cost of any medical and surgical procedures and treatment incurred by me, including those charged to me but not authorized by my health care agent, from the person or persons authorizing or directing that such treatment be provided.
- H. To request, review and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records to the same extent that I am entitled to and to execute on my behalf, any documents that may be required to obtain this information and to disclose or consent to the disclosure of this information to others who have a legitimate need to know.
- L. Where necessary, to implement the health care decisions that my health care agent is authorized by this document to make, to execute on my behalf any documents titled or purported to be a "consent to permit treatment," "refusal to permit treatment," or "leaving hospital against medical advice"; or a waiver or release from liability required by a hospital, nursing facility, residential care facility, physician or any other health care provider.
- J. To make anatomical gifts of part or all of my body for medical purposes to authorize an autopsy and to direct the disposition of my remains, to the extent permitted by law and by paragraph 6 above.
- K. To take any other action necessary to do what I authorize in this document, including, but not limited to, pursuing any legal action in my name, and at the expense of my estate, to force compliance with my wishes as determined by my health care agent, or to speak actual or punitive damages for the failure to comply.

9. Binding Effect.

This Durable Power of Attorney for Health Care shall be binding upon me, my attending and any other treating physician, any medical treatment facility providing for my care, and my executors, administrators, heirs, successors and assigns.

10. Protection of Third Parties.

No person who relies in good faith upon any representation by my health care agent or any alternate agent shall be liable to me, my estate, my heirs or assigns for recognizing the health care agent's authority.

11. Designation of Guardian.

In the event it is necessary that a guardian be appointed by the court of any jurisdiction for the management of my person or property, I nominate my health care agent or alternates named above (each to act alone and successively in the order named as my health care agent) as my guardian.

12. Administrative Provisions.

- A. This Durable Power of Attorney for Health Care revokes any previous Power of Attorney or Living Will regarding my health care given by me.

- B. This Durable Power of Attorney for Health Care is intended to be valid in any state in which it is presented.
- C. My health care agent shall not be entitled to compensation for services performed under this Durable Power of Attorney for Health Care, but shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any of its provisions.
- D. The powers delegated under this document are separable, so that the invalidity of one or more powers shall not affect any others.
- E. To avoid the execution by me of a burdensome number of original copies of this instrument, I specifically direct that all parties affected by and acting upon its provisions may rely upon a photocopy thereof to facilitate its use and the consummation of the actions authorized herein.

BY SIGNING MY NAME BELOW, I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE AND THE EFFECT OF THIS GRANT OR POWER TO MY HEALTH CARE AGENT.

I have executed this document in two (2) originals on the _____ day of _____, 200_____.

(Principal)

The Principal voluntarily signed this document in my presence.

_____ of _____, _____
(Residential Town) (State)

_____ of _____, _____
(Residential Town) (State)

STATE OF _____)

:ss

COUNTY OF _____)

On this the _____ day of _____, 200_____, before me the undersigned officer, personally appeared _____, known to me or satisfactorily proven to be the person(s) whose name is subscribed to the within instrument as the Principal, and acknowledged that she executed the same for the purposes therein contained.

In witness whereof I have hereunto set my hand and official seal.

Notary Public

(SEAL)

My commission expires: