DURABLE POWER OF ATTORNEY FOR HEALTH CARE CHOICES
& HEALTH CARE CHOICES DIRECTIVE

6-PAGE FORM

Part I. Durable power of attorney for health care choices

I, _____, _____,
Name Social Security number

appoint

_____, _____,
Name Phone

_____
Address

as my agent for health care choices when I am unable to make decisions or communicate my wishes. In the case the person above cannot serve as my agent, or if I am divorced from or legally separated from the agent above, I appoint the person below:

_____, _____,
Name Phone

_____
Address

This alternate agent may make health care decisions for me when I am unable to do so or to communicate my wishes.

This durable power of attorney becomes effective when **two** physicians certify that I am incapacitated and unable to make and communicate health care choices.

You may choose to have one physician, instead of two, determine whether you are incapacitated. If you want to exercise this option — allowing one physician to determine whether you are incapacitated — initial here.

By completing this durable power of attorney, I authorize my agent to make all decisions for me regarding my health care. This includes the power to withdraw any type of health care, treatment or procedure, even if I may die in the process. I expect my agent to follow my health care choices directive. My agent has the power to:

- Consent, refuse or withdraw consent to artificially supplied nutrition and hydration.
- Make all necessary arrangements for health care on my behalf. This includes admitting me to any hospital, psychiatric treatment facility, hospice, nursing home or other health care facility.
- Hire or fire health care personnel on my behalf.
- Request, receive and review my medical and hospital records.
- Take legal action if necessary to do what I have directed.
- Carry out my wishes regarding autopsy and organ donation, and decide what should be done with my body.

My agent under this durable power of attorney will not incur any personal financial liability. The agent also should not be compensated for services performed for me. However, the agent shall be reimbursed for reasonable expenses that are part of my care.

THIS IS A DURABLE POWER OF ATTORNEY AND THE AUTHORITY OF MY ATTORNEY IN FACT, WHEN EFFECTIVE, SHALL NOT TERMINATE OR BE VOID OR VOIDABLE IF I AM OR BECOME DISABLED OR INCAPACITATED OR IN THE EVENT OF LATER UNCERTAINTY AS TO WHETHER I AM DEAD OR ALIVE.

Part II. Health care choices directive

I want those involved in my health care to understand my wishes if I cannot communicate or make decisions on my own. I make this directive to provide clear and convincing proof of my wishes and instructions about my health care and treatment.
If my doctor believes medical treatment will lead to my recovery, I want to have the treatment. I also want to have care and treatment for pain or discomfort even if this treatment might shorten my life, affect my appetite, slow my breathing or be habit-forming.

If I have a terminal illness or condition and there is no reasonable hope I will recover, or if I am persistently unconscious, I direct all of the life-prolonging procedures I have initialed below to be withheld or withdrawn.

I direct the following treatments to be withheld or withdrawn:

- ☐ Surgery or other invasive procedures
- ☐ Cardiopulmonary resuscitation (CPR) to restart my heart or breathing
- ☐ Antibiotics
- ☐ Dialysis
- ☐ Mechanical ventilator (respirator)
- ☐ Artificially supplied nutrition and hydration (including tube feeding)
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ All other "life-prolonging" medical treatments or surgeries that are merely intended to keep me alive without reasonable hope of making me better or curing my illness or injury.
- ☐ I consent to the donation of my organs or tissues. I realize my body may need to be maintained artificially after my death until my organs can be removed.
- ☐ I refuse to make anatomical gifts of part or all of my body. I prohibit my agent from consenting to such gifts before or after my death.

I also give the following directions regarding my health care:

_____

_____

_____

_____

_____

_____

Optional: Describe what you consider an acceptable quality of life. For example, being able to recognize my loved ones, make decisions, communicate or feed yourself.

_____

_____

_____

_____

_____

_____

Attach extra pages if necessary. Sign and date the attached pages.

Make sure to talk about this directive and your wishes with your agent, your doctors, family, friends and clergy. Give each of them a copy of the directive. Bring a copy with you when you go to a hospital or other health care facility. Keep the original with your important papers.

Part III. Relationship between health care choices directive and durable power of attorney for health care choices

As I have executed the health care choices directive and durable power of attorney for health care choices, I trust and encourage my agent to:

- First, follow my wishes as expressed in the directive or otherwise from knowledge about me or having had discussions with me about making choices regarding life-prolonging medical treatment.
- Second, if my agent does not know my wishes for a specific decision, but my agent has evidence of what I might want, my agent can try to figure out how I would decide. This is called substituted judgment and requires my agent imagining himself or herself in my position. My agent should consider my values, religious beliefs, past choices and past statements I have made. The aim is to choose as I probably would choose, even if it is not what my agent would choose for himself or herself.
- Third, if my agent has very little or no knowledge of what I would want, then my agent and the doctors will have to make a decision based on what a reasonable person in the same situation would decide. This is called making decisions in my best interest. I have confidence in my agent's ability to make decisions in my best interest if my agent does not have enough information to follow my preferences or use substituted judgment, and if this is the case, I authorize my agent to make decisions that might even be contrary to my directive in his or her best judgment.
- Finally, if the durable power of attorney for health care choices is determined to be ineffective, or if my agent is unable to serve, the health care choices directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.

Sign this form before two witnesses who are not related to you or financially connected to your estate.

IN WITNESS THEREOF, I have executed this document on _____ _____, _____.
MONTH DAY YEAR

Signature _____

Print name _____ SS No._____

Address _____

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

Signature _____ Signature _____

Print name _____ Print name _____

Address _____ Address _____

_____ _____

Notarization required

STATE OF MISSOURI)
) SS
COUNTY OF _____)

On this ____ day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed.

IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of _____, State of Missouri, the day and year first above written.

_____
Notary public's signature

Missouri Department of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010
RELAY MISSOURI for Hearing and Speech Impaired 1-800-735-2966 VOICE 1-800-735-2466

Bret Fischer
Acting Director

Eric R. Greitens
Governor

Missouri Organ and Tissue Donor Registry Enrollment Information Sheet

Missouri's Organ and Tissue Donor Registry is a confidential list of organ, tissue and eye donors maintained by the Missouri Department of Health and Senior Services. You are not required to be on the registry to be a donor and can remove your name at any time. You may also amend or revoke your decision at any time. Placing your name on the registry means you consent to have your organs and tissues given to others upon your death. First-person consent makes your decision final unless revoked in a manner provided by law. If you would like to be on Missouri's Organ and Tissue Donor Registry, please complete this form and submit as instructed on the form.

Informed Consent: By completing the enrollment form, I understand that:

1. My information will be kept confidential and will only be used for official registry use and to coordinate my gift.
2. My donation is a gift. There is no cost to me, my family or my estate for my gift. My family or estate will receive no money for my gift. It is unlawful for anyone to sell organs or tissues for any reason. All costs and expenses incurred after my death and relating to my donation through the recovery of the organs, eyes and tissues will be the donor agencies' responsibility. Medical costs not related directly to donation and funeral costs are the responsibility of my estate, family or other responsible party.
3. My gift is only valid after I am declared dead by a licensed doctor who is not part of the recovery or transplant process.
4. The hospital and the donor agency will assess my gift potential at the time of my death to make sure it is safe to use my gift for others. Please note that under Missouri law, a donor's gift can be examined, including a review of the donor's complete medical record, to determine the suitability for donation by persons involved in the organ or tissue donation process. I understand and release the donor agency to notify my family at the time of death of my decision and to ask them to participate in the process by providing information about my social and medical history. I understand it is important for me to communicate my decision to my family so they can help honor and respect my choice.
5. If blood test results are positive for any reportable condition/disease that may affect others, the results will be sent to the Department of Health and Senior Services as required by Missouri law.
6. Every donor is treated with great care and dignity during the donation process including careful reconstruction of one's body. Donation as a rule does not delay funeral plans.
7. Recovered tissues may be used in different forms to help more people. For example, skin may be used to create a skin graft for burn patients.
8. Donated organs, eyes and tissues are given to people who need them the most. Typically at the local level first, then the region, and finally all over the country. Under certain circumstances, organs, eyes and tissues may be sent out of the country to help patients in need.
9. I may limit my donation to certain portions of my body and/or for certain purposes (transplantation/therapy, research/education, or both.)
10. I understand that any person acting in accordance with sections 194.210 to 194.294, RSMo or with applicable anatomical gift law of another state that is not inconsistent with Missouri's law or any person that attempts without negligence and in good faith to do so is not liable for the act in any civil action, criminal, or administrative proceeding. I also understand that neither I nor my estate is liable for any injury or damage that results from the making or use of the gift.

Amend Consent: You may amend your registry record by going to www.missouriorgandonor.com (Update My Profile) or by completing a paper Enrollment Application (http://health.mo.gov/living/organdonor/pdf/enrollment_application.pdf). If completing a paper enrollment, please complete and submit as instructed on the form.

Revocation: You may withdraw or revoke your consent to be listed on the registry. This action does not mean a refusal to make an anatomical gift. Other authorized persons may make such a gift for you unless you take steps to prevent them from doing so. To revoke you must complete a Removal Application available at http://health.mo.gov/living/organdonor/pdf/removal_form.pdf, or call 888-497-4564. Print, sign and mail or fax the form using the information provided at the bottom of form.

Refusal: If you refuse to make an anatomical gift and want to bar others from doing so on your behalf, you may execute a refusal by completing one of the steps below. Be sure to provide copies of your documentation to family, friends, or others who may be making end-of-life decisions for you. This information will not be included in the registry or be maintained by the Department of Health and Senior Services.

- A record or writing signed by you.
- A will.
- A record or writing signed by another person at your direction, if you are physically unable to sign, and witnessed by at least two adults, one being a disinterested witness, who sign at your request and attest to such act.
- A communication made by you in any form during your terminal illness or injury, addressed to at least two adults, one of whom is a disinterested witness.

Questions: Answers to general donation questions can be found at: **www.missouriorgandonor.com**. If you have questions about procedures related to transplants or donation, please contact one of the following agencies:

Midwest Transplant Network	Mid-America Transplant	Saving Sight
(**http://www.mwtn.org/**)	(**http://www.midamericatransplant.org/**)	(**https://saving-sight.org/**)

www.health.mo.gov

Healthy Missourians for life.
The Missouri Department of Health and Senior Services will be the leader in promoting, protecting and partnering for health.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF COMMUNITY AND PUBLIC HEALTH

ORGAN AND TISSUE DONOR REGISTRY ENROLLMENT APPLICATION

This will serve as your document of gift. Much of the information on this form is required, so please be sure the form is complete. You will receive an email or letter confirming your enrollment, or in the event information needs to be clarified and/or verified. E-mail may also be used to send out new information about organ and tissue donation and the registry. Call toll-free if you have questions: 888-497-4564

Complete the following information to be added to the registry or to amend a gift.

PARTICIPANT'S NAME (LAST) **(FIRST)** **(MIDDLE)** **(SUFFIX)**

ADDRESS (MAILING) **(CITY)** **(STATE)** **(ZIP CODE)**

COUNTY OF RESIDENCE

GENDER ☐ **Male** ☐ **Female**

EMAIL ADDRESS

PHONE

DATE OF BIRTH (Month/Day/Year)

_____ / _____ / _____

SOCIAL SECURITY NO. or DRIVER LICENSE NO.

My donations are for the following purposes: (Check one)
☐ Transplant/Therapy Only
☐ Research/Education Only
☐ Both Transplant and Research

GIFT SPECIFICATIONS (Check one)
I would like to donate
☐ Any needed organs and tissues, as allowed by law.
☐ Any needed organs and tissues as allowed by law, with the following restrictions:
Restrictions: _____

RACE (optional)
☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Other Pacific Islander
☐ American Indian or Alaska Native ☐ Other _____

ETHNICITY (optional)
☐ Not Hispanic or Latino
☐ Hispanic or Latino
☐ Other _____

How did you learn about the Missouri Donor Registry? (optional)
☐ DMV ☐ Newspaper ☐ Mid-America Transplant
☐ Family ☐ Radio ☐ Midwest Transplant
☐ Friend ☐ TV ☐ Saving Sight
☐ Other _____

I am participating in a Donor Registry Event (if applicable) (optional)
_____

What prompted you to register? (optional)
☐ Driver's License Office ☐ Friend Needs A Transplant
☐ Event ☐ Friend Was A Donor
☐ Family Member ☐ Loved One Was A Donor
☐ Family Member Needs A Transplant ☐ My Personal Belief System
☐ Friend ☐ Other _____

INITIAL THE APPROPRIATE CATEGORY
___ I affirm that I am age 18 or over and am able to give full legal consent to organ/tissue donation.
___ I affirm that I am under the age of 18, an emancipated minor and able to give full legal consent to organ/tissue donation.
___ I affirm that I am under the age of 18 but at least 16, I am not emancipated and therefore providing contact information for my parents/guardians below.
___ I am the parent/guardian of the child being enrolled in the registry. My relationship to the child is: _____
I affirm that I am the person named above and the information provided is true and correct. I understand my registration serves as my document of gift, my gift does not require the consent of another person, I may remove my name at any time, and I may revoke a part or all of my decision to gift.

SIGNATURE (Required of applicant or parent if enrolling a child.)

ENROLLMENT DATE

WITNESS SIGNATURE
(Required if adult is physically unable to sign including due to terminal illness or injury)

DISINTERESTED WITNESS SIGNATURE
(Required if adult is physically unable to sign including due to terminal illness or injury)

NAME AND CONTACT INFORMATION FOR PARENTS/GUARDIANS **(LAST)** **(FIRST)** **(MIDDLE)**

ADDRESS (MAILING) **(CITY)** **(STATE)** **(ZIP CODE)**

PHONE NUMBER

Fax or mail completed form to:
Missouri Organ and Tissue Donor Program
Missouri Department of Health and Senior Services
PO Box 570
Jefferson City, MO 65102-0570

Phone (toll-free) 888-497-4564
Fax: 573-522-2898

A confirmation will be sent to you.