# **DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS**

## DECISION TO NAME SOMEONE TO SPEAK FOR ME

I, (your name)	_ (date of birth)	, appoint the following person(s) to				
make healthcare decisions for me when I am unable to make or communicate my own wishes:						
Agent may not be the treating healthcare provider, an emplo	yee of the treating hea	althcare provider,	or an employee, owner,			
director or officer of a facility, unless that person is a relative	e or is bound to you by	y common vows to	o a religious life.			
PLEASE PRINT:						
Name of Agent:						
Name of Agent		Telephone	Telephone			
Agent's address:	City		State/Zip			
Name of First Alternate Agent:						
		Telephone	Telephone			
Agent's address:	City		State/Zip			
Name of Second Alternate Agent:						
		Telephone	Telephone			
Agent's address:	City		State/Zip			

This power of attorney for healthcare decisions shall become effective when I am unable to make decisions or unable to communicate my wishes regarding healthcare. This power of attorney for healthcare decisions shall not be affected by my subsequent disability or incapacity. Any durable power of attorney for healthcare decisions I have previously made is hereby revoked.

### **AUTHORITY GRANTED**

#### My healthcare agent may:

- 1. Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition;
- 2. Make all arrangements for me at any hospital, treatment facility, hospice, nursing home or similar institution;
- 3. Employ or discharge healthcare personnel including physicians, psychiatrists, dentists, nurses, therapists or other persons who provide treatment for me;
- 4. Request, receive and review any information, spoken or written, regarding my personal affairs or physical or mental health including medical and hospital records, and execute any releases or other documents that may be required in order to obtain such information; and
- 5. Make decisions about organ and tissue donations, nd the disposition of my had autopsy

#### My agent shall authorize consent for the following special instructions:

- $\Box$  I wish to be a donor for organs and tissues.
- □ I have attached information about treatment choices I wish to have honored by my agent. \_\_\_\_ page(s) attached.

#### LIMITATIONS ON AUTHORITY GRANTED My healthcare agent may not:

- 1. Exceed the powers set out in writing in this document; or
- 2. Revoke any existing Living Will Declaration I may have.

Notary Public:	Notary Seal:
STATE OFCOUNTY OF	
This instrument was acknowledged before me this	day of (month, year)
Signature of Notary	
or	
<i>OT</i> Witnesses: (witnesses may not be the age	nt or a relative, or beneficiary of the principal)

X \_\_\_\_\_\_signature

3306 E. Central, Wichita, KS 67208 316-686-7172 www.wichitamedicalresearch.org date

# LIVING WILL DECLARATION

### Kansas Natural Death Act

I,\_\_\_\_\_, being

of sound mind, willfully and voluntarily making known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any

medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this decision. Any Living Will declaration I have previously made is hereby revoked.

Declarations made this	_ (day) of	(month, ye	ear)			
Signature:						
X	D	ate of Birth				
Address:		city	state	zip		
This document must be witnessed by two individuals or acknowledged by a notary public.						
Notary Public:			Notary S	Seal:		
STATE OFCOUNTY O	)F					
This instrument was acknowledged before me this	day of	(month, year)				
Signature of Notary		-				
or						
Witnesses: The declarant has been personally known to me and I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly responsible for declarant's medical care.						
Name:	Na	me:				
Address:	Ad	dress:				
City, State, Zip:	Cit	y, State, Zip:				



This document is based on Kansas Statute 65-28,101 et seq. as amended Additional forms and information are available through

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# DNR DO-NOT-RESUSCITATE DIRECTIVE

K.S.A. 65-4941, ET. SEQ.

<b>DECISION TO LIMIT EMERG</b>	ENCY MEDICAL CARE				
(Your name), request that effective					
today, emergency care for me will be limited as described below.					
If my heart stops beating or if I stop breathin breathing or heart functioning will be institute	•				
• I understand that the procedure I am refusing, k resuscitation, (CPR), includes chest compression defibrillation, administration of cardiotonic med procedures.	ns, assisted ventilations, intubation,				
• I do not intend for this decision to prevent me freespecially comfort measures and pain medication					
• I understand I may revoke this directive at any time.					
• I give permission for this information to be given doctors, nurses or other health care personnel.	n to emergency care providers,				
<ul> <li>This DNR directive shall remain in effect while facility or care home as well as during transport</li> <li>X</li></ul>					
X(Witness Signature)	(Date)				
<ul> <li>Attending Physician Order: I have discussed with this patient and recognize the patient's decis</li> <li>In the event of an acute cardiac or respiratory a shall be attempted. DNR</li> </ul>	ion to refuse CPR.				
X(Attending Physician's Signature)	(Date)				
(Address)	(Facility, Clinic or Hospital Name)				
<b>Revocation:</b> I hereby withdraw the above DNR X (Signature)	directive.				



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We thank Kansas Health Ethics, Inc. (now closed) for their efforts in the development of this and other documents. For more information about obtaining copies of this document contact Wichita Medical Research & Education Foundation, 316-686-7172 or tcarter@wichitamedicalresearch.org, www.wichitamedicalresearch.org