DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(usually referred to as DPOAH)

I, ______________________________, hereby appoint ______________________________
(Name) (Name of Health Care Agent)

of ____
(Health Care Agent's address and phone #)

as my health care agent to make any and all health care decisions for me, except if I state otherwise in this document, or as prohibited by law. This Durable Power of Attorney for Health Care shall take effect in the event I become unable to make my own health care decisions.

In the event the person I choose as health care agent is unable, unwilling, unavailable or ineligible to act as my health care agent, I choose ______________________________
(Name of alternate health care agent)

of ______________________________________ as alternate health care agent.
(Address and phone # of alternate health care agent)

Statement of Desires, Special Provisions, and Limitations about Health Care Decisions

Some general statements about the withholding or removal of **life-sustaining treatment** are used in this document. Life-sustaining treatment is defined as procedures without which a person would die. Some of these are: cardiopulmonary resuscitation, mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions and antibiotics.

If I wish to indicate my agreement or disagreement with each of the following statements I will circle my choice and initial the line beside it, and give my health care agent power to act in these specific circumstances.

1. If I become permanently incompetent to make health care decisions, and if I am also suffering from a terminal illness, I authorize my health care agent to direct that life-sustaining treatment be discontinued. *(Circle your choice and initial beside it.)*

   YES __________ (Initials) NO __________ (Initials)

2. Whether terminally ill or not, if I become permanently unconscious, I authorize my health care agent to direct that life-sustaining treatment be discontinued. *(Circle your choice and initial beside it.)*

   YES __________ (Initials) NO __________ (Initials)

3. I realize that situations could arise in which the only way to allow me to die would be to discontinue artificial nutrition and hydration. In carrying out any instructions I have given in this document, I authorize my health care agent to direct that my choices indicated below be respected.

   I wish to have my life continued with artificial feeding or artificial hydration.

   YES __________ (Initials) NO __________ (Initials)

   If artificial feeding and hydration have been started, I want them:

   STOPPED __________ (Initials) CONTINUED __________ (Initials)

   I understand that if I do not complete item number 3, my health care agent will NOT have the power to stop artificial feeding and hydration.

I wish to be given medication which is necessary to control my pain without regard to any of the above choices.

YES __________ (Initials) NO __________ (Initials)

4. I understand that in this paragraph I may write specific desires I want or don't want, may attach extra pages or may leave this question blank.
Under what conditions would you want the goals of medical treatment to switch from trying to continue your life to focusing on your comfort? What will be important to you when you are dying (comfort, no pain, family present, music, pray, be held etc.)? Do you want to indicate a timeframe for trying treatment options?

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I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this document. I have read and understand the information in the disclosure statement.

The original of this document will be kept at ______________________________ (Address) and the following persons and institutions will have copies:

____

____

____

In witness to this, I sign my name this __________ (Day) day of ______________ (Month), 20____ (Year).

Signed ____ (Your Name)

I declare that the principal appears to be of sound mind and free from duress at the time the Durable Power of Attorney for Health Care is signed, and that the principal has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

Witness ____________________________________ Address ____________________________________

Witness ____________________________________ Address ____________________________________

To be completed by notary:

State of ____________________________________ County of ____________________________________

The foregoing instrument was acknowledged before me this _______ (Day) day of _______ (Month), 20___ (Year).

Notary Public/Justice of the Peace ______________________________ My commission expires: ________

Make copies of these two pages for your doctor, hospital, health care agent and family

LIVING WILL

On this ________ day of ________ I, ____
being of sound mind, willfully and voluntarily state that my dying should not be artificially prolonged because of medical care being given to me, if the following things happen:

- If I have a disease, injury, or illness that can't be cured, or
- If I am permanently unconscious,
- And if these conditions are stated by two doctors who have examined me themselves, one of whom is my attending doctor,
- And if the doctors have determined that I will die even if I am given life-sustaining treatment, or that I will remain permanently unconscious,
- And if this life-sustaining but artificial treatment will only make my dying take longer,

I direct that these life-sustaining treatments shall not be given, or be stopped, and that I die naturally, with only the medication, sustenance or medical procedures that are necessary to give me comfort care.

I know that situations could arise in which the only way to allow me to die would be to stop artificial feeding and hydration (fluids). I state that *(circle your choice and initial beside it)*:

I wish to have my life continued with artificial feeding or artificial hydration.

YES __________ (Initials) NO __________ (Initials)

If artificial feeding and hydration have been started, I want them:

STOPPED __________ (Initials) CONTINUED __________ (Initials)

If I cannot give directions about using such life-sustaining treatment, it is my intention that this declaration shall be honored by my family and doctors as the final expression of my right to refuse medical or surgical treatment and to accept the consequences of refusing it.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Signed ____________________________________
(Your Name)

State of ______________________________ County ______________________________

We, the following witnesses, being duly sworn, each declare to the notary public or justice of the peace or other official signing below that:

1. The declarant signed this document as a free and voluntary act for the purposes expressed, or expressly directed another to sign for him.
2. Each witness signed at the request of the declarant, in his or her presence, and in the presence of the other witness.
3. To the best of my knowledge, at the time of the signing the declarant was at least 18 years old, and was of sane mind and under no constraint or undue influence.

Witness ______________________________

Witness ______________________________

The Affidavit shall be made before a notary public or justice of the peace or other official authorized to administer oaths in the place of execution, who shall not also serve as a witness, and who shall complete and sign a certificate in content and form substantially as follows:

To be completed by notary.

Sworn to and signed before me by ____, declarant

____

and ____, witnesses, on ______________________.
(Date)

Signature ________________________ Official Capacity ____________________________

Make copies of these two pages for your health care providers, hospital, health care agent and family