Power of Attorney for Health Care of _____

Notice to Person

Making this Document

YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.

BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES HAVE NOT HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.

TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT AS YOU WISH. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES THE PERSON WHOM YOU SPECIFY BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU CHANGE YOUR MIND ABOUT WHETHER A PERSON SHOULD MAKE HEALTH CARE DECISIONS FOR YOU, OR ABOUT WHICH PERSON THAT SHOULD BE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING THE DOCUMENT OR DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, REVOKING IT IN A WRITTEN STATEMENT WHICH YOU SIGN AND DATE OR STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY THE PERSON YOU HAD SPECIFIED, YOUR HEALTH CARE PROVIDERS, AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF THE PERSON YOU HAVE SPECIFIED IS YOUR SPOUSE AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND WHAT IT MEANS.

IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.

Power of Attorney for Health Care

I, _____, hereby appoint _____ as my attorney-in-fact (my "Agent") to act for me and in my name, in any way I could act in person, with respect to my personal care, upon the determination of my

incapacity by any physician or licensed psychologist who has personally examined me and has made such determination in writing. My Agent shall have the power:

1. To request, review, and receive any information, verbal or written, regarding my personal affairs or my physical or mental health, including medical and hospital records and court records, and to execute any releases or other documents that may be required to obtain this information.

2. To employ and discharge physicians, psychiatrists, dentists, nurses, therapists, and other professionals as my Agent may deem necessary for my physical, mental, and emotional well being, and to pay them, or any of them, reasonable compensation.

3. To give or withhold consent to my medical care, surgery, or other medical procedures or tests; to arrange for my hospitalization, convalescent care, or home care; to consent to my admission to a nursing home or community-based residential facility for any purpose, so long as I have not been diagnosed as being developmentally disabled or having a mental illness at the time of the proposed admission; and to revoke, withdraw, modify, or change consent to my medical care, surgery, or any other medical procedures or tests, hospitalization, convalescent care, or home care which I or my Agent may have previously allowed or consented to or which may have been implied on account of emergency conditions. I ask that my Agent be guided in making those decisions by what I have indicated about my personal preferences regarding that care. Based on those same preferences, my Agent may also summon paramedics or other emergency medical personnel and seek emergency treatment for me, or choose not to do so, as my Agent deems appropriate given my wishes and my medical status at the time of the decision. My Agent is authorized, when dealing with hospitals and physicians, to sign documents titled or purporting to be a "Refusal to Permit Treatment" or "Leaving Hospital Against Medical Advice" as well as any necessary waivers of or releases from liability required by the hospitals or physicians to implement my wishes regarding medical treatment or nontreatment.

4. To direct that aggressive medical therapy not be instituted or be discontinued, including, but not limited to, cardiopulmonary resuscitation, the implantation of a cardiac pacemaker, renal dialysis, parental feeding, the use of respirators or ventilators, blood transfusions, nasogastric tube use, antibiotics and organ transplants. My Agent should try to discuss the specifics of any such decision with me if I am able to communicate in any manner, even by blinking my eyes. If I am unconscious, comatose, senile, or otherwise unreachable by such communication, my Agent should make the decision guided primarily by my preferences which I may have previously expressed, and secondarily by the information given by the physicians treating me as to my medical diagnosis and prognosis. My Agent is authorized to specifically request and concur with the writing of a "no-code" (DO NOT RESUSCITATE) order by the attending or treating physician.

5. To consent to and arrange for the administration of pain relieving drugs of any type, or other surgical or medical procedures calculated to relieve my pain even though their use may lead to permanent physical damage, addiction, or even hasten the moment of (but not intentionally cause) my death. My Agent may also consent to and arrange for unconventional pain relief therapies, such as biofeedback,

guided imagery, relaxation therapy, acupuncture, or cutaneous stimulation, and other therapies which I or my Agent believes may be helpful to me.

6. To exercise my right of privacy to make decisions regarding my medical treatment and my right to be left alone even though the exercise of my right may hasten my death or be against conventional medical advice. My Agent may take appropriate legal action, if necessary, to enforce my rights in this regard.

I give and grant unto my Agent full power and authority to do and perform every act and thing whatsoever necessary, proper or convenient to be done in the premises as fully to all intents and purposes as I might and could do for myself. [In the event of my pregnancy, this power of attorney shall remain in full force and effect.] I hereby ratify and confirm all that my Agent shall lawfully do or cause to be done by virtue of this power and hold harmless any person or entity who suffers loss or liability from reliance upon this Power of Attorney.

If it becomes necessary to appoint a guardian of my person after the execution of this Power, I nominate the Agent acting under this Power of Attorney as such guardian to serve without bond or security.

If my Agent resigns, dies or becomes incompetent, then I appoint the following individuals as substitute Attorney-in-Fact, each to act alone and successively in the order named, with all the same powers as given to the original Attorney-in-Fact: _____ and _____. For purposes of this paragraph, a person shall be considered to be incompetent if the person is adjudicated incompetent or the person is unable to give prompt and intelligent consideration to health care matters as certified by a licensed physician.

I direct that the powers granted herein to my Agent be considered as severable and distinct from one another so that, if any such power is held to be invalid or unenforceable, this Power of Attorney shall be construed as if the invalid or unenforceable power had not been included herein.

I am fully informed as to all of the contents of this Power of Attorney and understand the full import of this grant of powers to my Agent.

[Date] [Signature of principal]

I know the principal personally and I believe h— to be of sound mind and at least 18 years of age. I believe that h— execution of this Power of Attorney for Health Care is voluntary. I am at least 18 years of age and am not related to the principal by blood, marriage, or adoption. I am not a health care provider who is serving the principal at this time. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

[Date] [Signature of Witnesses, noting city and state of residence]