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# **ADVANCED DIRECTIVE AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE**

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## **Explanation**

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

This form is a power of attorney for health care. It lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community-care facility or a residential care facility where you are receiving care or your supervising health-care provider or employee of the health-care institution where you are receiving care, unless your agent is related to you or is a co-worker.)

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition;
- b) Select or discharge health-care providers and institutions;
- c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication;
- d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation; and

e) Make anatomical gifts, authorize an autopsy, and direct the disposition of your remains.

This form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive. After completing this form, sign and date the form at the end. The form must be acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this Advanced Directive Durable Power of Attorney for Health Care or replace this form at any time.

## 1. DESIGNATION OF AGENT

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I, \_\_\_\_\_ designate the following individual as my agent to make health care decisions for me:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 2. AGENT'S AUTHORITY:

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My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive.

## 3. WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:

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My agent's authority to make health-care decisions for me takes effect immediately.

## 4. AGENT'S OBLIGATION:

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My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

## 5. AGENT'S POSTDEATH AUTHORITY:

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My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here on this form:

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## 6. NOMINATION OF CONSERVATOR:

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If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

## 7. END-OF-LIFE DECISIONS:

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I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (Initial only one line)

\_\_\_\_\_ (a) Choice **NOT** to Prolong Life

I do not want my life to be prolonged if (1) I have an incurable, and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

\_\_\_\_\_ (b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

## 8. RELIEF FROM PAIN:

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I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death.

## 9. EFFECT OF COPY:

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A copy of this form has the same effect as the original.

**10. SIGNATURE:**

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Sign and date the form here:

\_\_\_\_\_ (Date) \_\_\_\_\_ (Your Signature)

\_\_\_\_\_ (Address) \_\_\_\_\_ (Print Your Name)

\_\_\_\_\_ (City) \_\_\_\_\_ (State)  
.....

State of \_\_\_\_\_  
County of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_  
Before me,

\_\_\_\_\_ personally appeared

\_\_\_\_\_ personally known to me  
(or proved to me on the basis of satisfactory evidence) to be the person whose  
name is subscribed to this instrument, and acknowledged that he or she  
executed it. I declare under penalty of perjury that the person whose name is  
subscribed to this instrument appears to be of sound mind and under no duress,  
fraud, or undue influence.

\_\_\_\_\_ (Signature of Notary Public) \_\_\_\_\_ (Notary Seal)

I declare under penalty of perjury that the person who signed this advance health-care directive is personally known to us, or that the signer's identity was proven to us by convincing evidence, (2) that the signer acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that we are not a person appointed as an agent by this advance directive, (5) that we are not the individual's health-care provider, an employee of the individual's health-care provider, the operator or employee of a community-care facility, nor the operator or employee of a residential-care facility for the elderly. We further declare that we are not related to the signer of this advance health care directive by blood, marriage, or adoption, and, to the best of my knowledge, we are not entitled to any part of the estate of the signer when he or she dies.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness Signature)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Print Name of Witness)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State)

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\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness Signature)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Print Name of Witness)

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(City)

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(State)