

MEDICAL DURABLE POWER OF ATTORNEY

1. DESIGNATION OF HEALTH CARE AGENT. I, _____,
of _____, appoint:

Agent Name: _____

Agent Address: _____

Phone: _____(Home)_____ (Work)

Relation, if any: _____

as my Agent to make health care and personal decisions for me if I become unable to make such decisions for myself, except to the extent I state otherwise in this document.

NOTICE: Generally you should not appoint any of the following persons as your Agent:

1. your treating physician or health care provider;
2. an employee of your physician or health care provider unless the person is your relative;
3. your residential care provider; or
4. an employee of your residential care provider unless the person is your relative.

The term "health care" as used in this document includes all medical treatment, the provision, withholding or withdrawal of any health care medical procedure, including artificially provided nutrition, nourishment and hydration (fluids), surgery, cardiopulmonary resuscitation, or service to maintain, diagnose, treat or provide for a patient's physical or mental health or personal care, unless such authority is otherwise limited by this document.

2. CREATION OF MEDICAL DURABLE POWER OF ATTORNEY. By this document I intend to create a Durable Power of Attorney. This Durable Power of Attorney shall take effect upon my disability, incapacity, or incompetency, and shall continue during such disability, incapacity, or incompetency.

3. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I grant to my Agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In making any decision, my Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. This document and the authority granted to my Agent shall have priority over any living will signed by me.

In exercising this authority, my Agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my Agent. If my desires

regarding a particular health care decision are not known to my Agent, then my Agent shall make the decision for me based upon what my Agent believes to be in my best interests.

4. SPECIAL PROVISIONS REGARDING MY HEALTH CARE. (For example, describe your wishes regarding any treatment you desire or do not desire, or admission to a residential care facility.)

5. STATEMENT OF VALUES AND PREFERENCES. (Specify any other wishes, values, religious beliefs, philosophy or other personal values or preferences that are relevant to your instructions. You may also state preferences concerning the location of your care.)

6. LIMITATIONS ON THE DECISION MAKING AUTHORITY OF MY AGENT:

7. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my Agent has the power and authority to:

- a. Request, review and receive any information, verbal or written regarding my physical or mental health, including, but not limited to, medical and hospital records;
- b. Consent to the disclosure of this information to others.

8. SIGNING DOCUMENTS, WAIVERS AND RELEASES. Where necessary to implement the health care decisions that my Agent is authorized by this document to make, my Health Care Agent has the power and authority to execute on my behalf any of the following:

- a. Documents to authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care or assisted living or similar facility or service;

- b. Documents titled or purporting to be “Consent to Permit Treatment” or “Refusal to Permit Treatment”;
- c. Any necessary waiver or release from liability required by a hospital or physician.

9. AUTOPSY, ANATOMICAL GIFTS, DISPOSITION OF REMAINS. I authorize my Agent, to the extent permitted by law, to make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains.

10. DESIGNATION OF ALTERNATE AGENT. If the person designated as my Agent is not available to act, I designate the following persons to serve as my Agent to make health care decisions for me as authorized by this document, who serve in the following order:

FIRST ALTERNATE AGENT

Agent Name: _____
 Agent Address: _____

 Phone: _____ (Home) _____ (Work)

11. NOMINATION OF GUARDIAN. If a Guardian of my person is to be appointed for me, I nominate my Agent (or Alternate Agent) to serve as my Guardian.

12. PRIOR DESIGNATIONS REVOKED. I revoke any prior Medical Durable Power of Attorney.

13: HOLD HARMLESS. All persons or entities who in good faith endeavor to carry out the terms and provisions of this document shall not be liable to me, my estate, my heirs or assigns for any damages or claims arising because of their action or inaction based on this document, and my estate shall defend the indemnify them.

14. SEVERABILITY. If any provision of this document is held to be invalid, such invalidity shall not affect the other provisions which can be given effect without the invalid provision, and to this end the directions in this document are severable.

15. STATEMENT OF INTENTIONS. It is my intent that this document be legally binding and effective. If the law does not recognize this document as legally binding and effective, it is my intent that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period which I am unable to make such decisions.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I have read and understand the contents of this document and the effect of this grant of powers to my Agent. I am emotionally and mentally competent to make this declaration.

Signed on the _____ day of _____, 20____.

Signature

Name _____
Address _____
City _____
County _____
State _____

Principal SSN: _____

STATEMENT OF WITNESSES

I declare that the person who signed or acknowledged this document (the “Principal”) has identified himself or herself to me, that the Principal signed or acknowledged this document in my presence, that the Principal appears to be of sound mind, and under no duress, fraud or undue influence. I am not the person appointed as Agent or alternate Agent by this document, nor am I a provider of health or residential care, an employee of a provider of health or residential care, the operator of a community care facility, or an employee or an operator of a health care facility.

I further declare that I am not related to the Principal by blood, marriage, or adoption, and to the best of my knowledge, I am not a creditor of the Principal or entitled to any part of the estate of the Principal under a will now existing or by operation of law.

Witness Signature: _____

Witness Name: _____

Witness Address: _____

Date: _____

Witness Signature: _____

Witness Name: _____

Witness Address: _____

Date: _____

State of _____,

County of _____

On this _____ day of _____, 20____, _____, known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public, within and for the said State and County, and acknowledged that he/she freely and voluntarily executed the same for the purposes stated in the document.

My commission expires: _____
Notary Public

The original of this document is kept at _____

The following individuals or institutions have signed copies:

Institution: _____
Address: _____

Individual Name: _____
Address: _____
