

**DESIGNATION OF ATTORNEY-IN-FACT**

Date of birth: \_\_\_\_\_

I, \_\_\_\_\_, of \_\_\_\_\_ (address) hereby appoint \_\_\_\_\_ (name of attorney-in-fact), of \_\_\_\_\_ (address and telephone number of attorney-in-fact) as my attorney-in-fact to consent to, to reject, or to withdraw consent for medical procedures, treatment, or intervention.

**SUCCESSORS**

In the event the person I appoint above is unable, unwilling, or unavailable to act as my health care agent, I hereby appoint (each to act alone and successively, in the order named) as successors to my attorney-in-fact:

**A. FIRST ALTERNATIVE ATTORNEY-IN-FACT**

\_\_\_\_\_  
Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
Telephone number

**B. SECOND ALTERNATIVE ATTORNEY-IN-FACT**

\_\_\_\_\_  
Name  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
Telephone number

**EFFECTIVE DATE AND DURABILITY**

By this document, I intend to create a durable power of attorney effective upon, and only during, any period of incapacity in which, in the opinion of my attorney-in-fact and attending physician, I am unable to make or communicate a choice regarding a particular health care decision.

**ATTORNEY-IN-FACT'S POWERS**

I grant to my attorney-in-fact full authority to make decisions for me regarding my health care. My attorney-in-fact may make any health care decisions for me which I could make individually if I had decisional capacity. However, all such decisions shall be made in accordance with accepted medical standards. Whenever making any health care decision for me, my attorney-in-fact shall consider the recommendation of the attending physician, the decision that I would have made if I had decisional capacity, if known by the attorney-in-fact, and the decision that would be in my best interest.

**Accordingly, unless specifically limited by Section 5 below, my attorney-in-fact is authorized as follows:**

- A. To consent, refuse or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including (but not limited to) artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;
- B. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;
- C. To authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care, assisted living or similar facility or service;
- D. To contract on my behalf for any health care related service or facility, without my attorney-in-fact incurring personal financial liability for such contracts;
- E. To hire and fire medical, social service and other support personnel responsible for my care;
- F. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death;
- G. To make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains, to the extent permitted by law; and
- H. To take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any hospital, physician, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my attorney-in-fact, or to seek actual or punitive damages for the failure to comply.

**STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS**

A. **LIMITATIONS** The powers granted above do not include the following powers or are subject to the following rules or limitations:  
\_\_\_\_\_  
\_\_\_\_\_

B. **LIFE-SUSTAINING TREATMENT** With respect to any life-sustaining treatment, I direct the following: (initial only one)

- \_\_\_\_\_ **REFERENCE TO A LIVING WILL.** I specifically direct my attorney-in-fact to follow any health care declaration or "living will" executed by me.
- \_\_\_\_\_ **GRANT OF DISCRETION TO ATTORNEY-IN-FACT.** I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my attorney-in-fact believes the burdens of the treatment outweigh the expected benefits. I want my attorney-in-fact to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.
- \_\_\_\_\_ **DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT.** I do not want my life to be prolonged and I do not want life-sustaining treatment if my death is imminent or I am permanently unconscious. If life sustaining treatment has been started, stop it, but keep me comfortable and control my pain.

**DIRECTIVE IN MY OWN WORDS**

**C. ARTIFICIAL NUTRITION AND HYDRATION**

Artificial nutrition and hydration is food and water provided by means of a nasogastric tube or tubes inserted into the stomach, intestines, or veins. With respect to artificial nutrition and hydration I wish to make clear that: *(initial one)*

- I do not want artificial nutrition and hydration started if they would be the only treatments keeping me alive. If artificial nutrition and hydration are started under these conditions, I want them stopped.
- I want artificial nutrition and hydration regardless of my condition.

**PROTECTION OF THIRD PARTIES WHO RELY ON MY ATTORNEY-IN-FACT**

No person who relies in good faith upon any representation by my attorney-in-fact or successor attorney-in-fact shall be liable to me, my estate, my heirs or assigns, for recognizing the attorney-in-fact's authority.

**NOMINATION OF GUARDIAN**

If a guardian of my person should for any reason be appointed, I nominate my attorney-in-fact (or his or her successor), named above.

**ADMINISTRATIVE PROVISIONS**

- A. I revoke any prior power of attorney for health care.
- B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.
- C. My attorney-in-fact shall not be entitled to compensation for services performed under this power of attorney, but he or she shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this power of attorney.
- D. The powers delegated under this power of attorney are separable, so that the invalidity of one or more powers shall not affect any others.

**By signing here I indicate that I understand the contents of this document and the effect of this grant of powers to my attorney-in-fact.**

**Signature:**     **X** \_\_\_\_\_  
 Print name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Date: \_\_\_\_\_

**WITNESS STATEMENT**

I declare that the person who signed or acknowledged this document is known to me, that he/she signed or acknowledged this durable power of attorney in my presence and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. **I am not the person appointed as attorney-in-fact by this document. I further declare that I am not related to the principal (person executing this document) by blood, marriage, or adoption, and to the best of my knowledge, I am not a creditor of the principal nor entitled to any part of his/her estate under a will now existing or by operation of law.**

**Witness** \_\_\_\_\_  
 Address \_\_\_\_\_  
**Witness** \_\_\_\_\_  
 Address \_\_\_\_\_

**NOTARIZATION**

STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_  
 On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, the said \_\_\_\_\_ 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 State and County aforesaid, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.  
 Notary Public: \_\_\_\_\_  
 My Commission Expires: \_\_\_\_\_



*Health Care  
 Power of  
 Attorney*

