DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(usually referred to as DPOAH)

I, ______________________________ (Name), hereby appoint ______________________________ (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 ______________________________ (Address and phone # of alternate health care agent) as 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:

____

____

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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