HEALTH CARE AGENT
MEDICAL DIRECTIVE / LIVING WILL
FOR

_____

PRINCIPAL	**HEALTH CARE AGENT / Attorney-in-Fact**
Name	**Name**
Address	**Address**
Phone	**Phone**

I. **Designation of Health Care Agent (Attorney-in-Fact):** If I am not capable of making health care decisions, I hereby appoint _____, my _____, as my Health Care Agent (Attorney-in-Fact), hereinafter referred to as "Agent", for the purposes set forth in this Directive / Living Will (hereinafter referred to as "Directive"). If my Agent is unable or unwilling to act, has died or is unable to be located, I then choose my successor Agent:

Name
Address
Phone

II. **Effective Date and Durability:** By this Directive 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 Agent after consulting with my attending physician(s), I am unable to make or communicate a choice regarding a particular health care decision. I revoke any prior Power of Attorney for this purpose.

III. **Agent's Powers:** Upon my inability to make my own decisions, I grant to my Agent full authority to make decisions for me regarding my health care. In making any decision, my Agent shall attempt to discuss the proposed decision with me to determine my desires. If they cannot determine my desires, then they shall jointly make a choice for me. My Agent's authority to interpret my desires is intended to be as broad as possible. My Agent is authorized as follows:

A. To consent, refuse or withdraw consent to any and/or 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. If the treatment or care has already started, my Agent can authorize its continued use or have it stopped;

B. To interpret the choices I have given in this form or have provided to my Agent in conversations regarding my care;

C. To authorize my admission to or discharge from any hospital, nursing home, residential care, or similar facility (even against medical advice from physicians and hospital staff and/or their representing agents).

D. To have access to all medical records and information to the same extent that I am entitled to;

E. To contract on my behalf for any health care related service or facility, without my Agent incurring any personal financial responsibility;

F. To hire and fire medical and other support personnel responsible for my care;

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.

IV. **Protection of Third Parties:** No person who relies in good faith upon my representations by my Agent or their successors shall be liable to me, my estate, my heirs or assigns, for recognizing my Agent's authority.

V. **Nomination of Guardian:** If a guardian of my person should for any reason be appointed, I nominate my Agent or their successor named above. I am not in favor of the appointment of any outside, hospital/physician-initiated, court-appointed guardian services.

VI. **Administrative Provisions:**

A. This Power of Attorney is intended to be valid in any jurisdiction.

B. The powers delegated under this Power of Attorney are separable, so that the invalidity of one or more powers shall not affect any others.

MEDICAL DIRECTIVE AND LIVING WILL
MEDICAL TREATMENT DECLARATION

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying be prolonged artificially or otherwise as decided upon by my acting Agent.

I. **Declaration:**

- If at any time I am diagnosed as being in an irreversible coma or persistent vegetative state; OR
- I have an incurable injury or illness considered to be a terminal condition; OR
- If my death will occur unless artificial life sustaining procedures are used; AND
- I am without reasonable hope of recovery with the ability to enjoy a quality of life thereafter, THEN

A. I DIRECT MY AGENT TO INSTRUCT MY PHYSICIAN(S):

That all life sustaining procedures, including artificially administered nutrition and fluids be withheld or withdrawn as decided upon by my acting Agent, except fluids administered for my comfort. Life sustaining procedures include major surgery, blood transfusions, dialysis and medical devices put in to assist with breathing; AND

I understand that in an effort to keep me pain free, the medication may cause me to be drowsy or to sleep more than I would otherwise; however, I am not consenting to euthanasia or assisted suicide by drug-induced coma; AND

It is my express wish that I be permitted to die naturally if possible, as decided upon by my acting Agent.

II. **My Understanding and Intent:**

A. I understand the full import of this Declaration, and I have the emotional and mental capacity to make this Declaration.

B. In the absence of my ability to give directions regarding the use of life sustaining procedures, it is my intention that this Declaration be honored by my Agent, family, attending physician(s) and hospital staff as the final expression of my legal right to medical and surgical treatment and the administration of life-sustaining treatment and nutrition.

III. **My Choices Regarding Comfort:**

- Please make certain that I am free of pain.
- I wish to be kept hydrated.

- I wish to be bathed regularly and kept clean.
- I direct that all my personal care/hygiene be seen to so long as the acts do not cause me any additional unreasonable discomfort.

IV. **My Choices For Care Giving:**

- Please arrange care givers or family visits so that I am not left alone for extended periods of time.
- My situation shall be made known to my church or synagogue, if any.
- The care givers (excluding family members) shall be certified for the level of care provided.
- My linens are to be changed daily if needed.
- My desire is to die, if possible, in my own home. If this is not possible, I wish my Agent to decide whether I be placed in a reputable hospice or care facility.

V. My legal next of kin who will have the responsibility to make my final arrangements is my husband.

PERSONAL IDENTIFICATION INFORMATION

Name:
Date of Birth:
Social Security Number:
Place of Birth:
Father's Name:
Mother's Maiden Name:

DATED and SIGNED this _____ day of _____, 2012 by:

_____
_____, Principal

_____ appeared before us and appeared to be of sound mind and free from duress at the time of the execution of this Medical Directive / Living Will. We are not designated to make medical decisions on this person's behalf, we are not related to this person in any way and we are not involved with provisions for health care for this person.

DATED and SIGNED this _____ day of _____, 2012 by:

_____
Witness

DATED and SIGNED this _____ day of _____, 2012 by:

_____
Witness