Health Care Power of Attorney
(Also known as a Medical Power of Attorney or Health Care Surrogate in some states).

You appoint an adult to make health care decisions for you when you become unable to make them for yourself. The person you select must agree in writing to the appointment.

The person you appointed may withhold or agree to any type of health care, medical and surgical treatments, life-prolonging interventions, nursing care, hospitalization, treatment in a nursing home, and home health.

Health Care Power of Attorney Decisions:

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate, for health care decisions:

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone No.: _____ Email Address: _____

If the person I have selected is unwilling or unable to perform his or her duties, I wish to designate:

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone No.: _____ Email Address: _____

(continued)

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the costs of health care; and to authorize my admission to or transfer from a health care facility.

Additional Instructions (optional):

I will notify and send a copy of this document to the following people so they may know whom I have appointed.

Name:

_____

Name:

_____

Living Will.

A Living Will (often called an advance directive) identifies the types of care a person does or does not want to receive in the event he or she becomes mentally incompetent during a terminal illness, or permanently comatose.

Living Will Decisions:

Yes _____. No _____. If I have a terminal condition and my attending doctor has determined that there is no medical probability of my recovery, I direct that life-prolonging procedures be withheld or withdrawn when they would serve only to prolong artificially the dying process, and that I be permitted to die naturally with only the administration of medication or the performance of a medical procedure to provide me with comfort or to alleviate pain.

_____ Yes, I do _____ No, I do not desire that nutrition and hydration (food and water) be withheld or withdrawn when they would serve only to prolong artificially the dying process.

My Living Will Agent's Name: _____

Address: _____

Phone No.: _____ Email Address: _____

My Living Will Alternate Agent's Name: _____

Address: _____

Phone No.: _____ Email Address: _____

Durable Power of Attorney.

If you become disabled or legally incapacitated, the Durable Power of Attorney goes into effect. As with a traditional Power of Attorney, it names the person who is authorized to act on your behalf when managing your financial affairs. The person you have appointed must agree in writing to serve in this role.

My Durable Power of Attorney Appointee's Name:

_____

Address: _____

Phone No.: _____ Email Address _____