Part A: Health Care Power of Attorney (Choosing a Health Care Agent)

If you do not wish to appoint a Health Care Agent, strike through this entire part and initial here _____.

My name is: _____ My birth date is: _____/_____/_____
(Please Print)

1. The person I choose as my health care agent is:

_____ _____ _____
first name middle name last name

_____ _____ _____ _____
street address city state zip code

_____ _____ _____ _____
home phone work phone cell phone e-mail address

If this person is unable or unwilling to serve as my health care agent, my next choice is:

_____ _____ _____
first name middle name last name

_____ _____ _____ _____
street address city state zip code

_____ _____ _____ _____
home phone work phone cell phone e-mail address

2. Special Instructions: In this section, you may include **any special instructions** you want your health care agent to follow, or **any limitations** you want to put on the decisions your health care agent can make, including decisions about tube feeding (artificial nutrition and hydration), other life-prolonging treatments, mental health treatments, autopsy, disposition of your body after death, and organ donation.

(Note: If you **DO NOT** have any special instructions for your health care agent, or any limitations you want to put on your agent's authority, please draw a line through this section.)

_____

_____

_____

_____

_____

3. Organ Donation:

_____ **(initial)** My health care agent may donate my organs or parts after my death.

(Note: if you do not initial above, your health care agent will not be able to donate your organs or parts.)

This form is not complete until notarized in Part C.

Part B: Living Will

If you DO NOT wish to prepare a Living Will, strike through this entire part and initial here _____.

My name is: _____ My birth date is: ___/_____ /_____
(Please Print)

1. **If I am unable to make or communicate health care decisions, I desire that my life not be prolonged by life-prolonging measures in the following situations:**
   (Note: you may initial **ANY or ALL** of these choices.)

   _____ **(initial)** I have a condition that cannot be cured and that will result in my death within a relatively short period of time.

   _____ **(initial)** I become unconscious and my doctors determine that, to a high degree of medical certainty, I will never regain my consciousness.

   _____ **(initial)** I suffer from advanced dementia or any other condition which results in the substantial loss of my ability to think, and my doctors determine that, to a high degree of medical certainty, this is not going to get better.

2. **Even though I do not want my life prolonged by other life-prolonging measures in the situations I have initialed in section 1 above, I DO want to receive tube feeding (artificial nutrition and/or hydration) in those situations, as stated below.** (Note: Initial only if you **DO WANT** tube feeding in those situations.)

   _____ **(initial) I DO want to receive artificial nutrition.**

   _____ **(initial) I DO want to receive artificial hydration.**

3. **I wish to be made as comfortable as possible.** I want my health care providers to keep me as clean, comfortable, and free of pain as possible, even though this care may not prolong my life.

4. **My health care providers may rely on this Living Will to withhold or discontinue life-prolonging measures in the situations I have initialed above.**

5. **If I have appointed a health care agent in Part A of this advance directive or a similar document, and that health care agent gives instructions that differ from the desires expressed in this living will, then:**
   (NOTE: Initial **ONLY ONE** of the two choices below.)

   _____ **(initial) Follow this living will.** My health care agent cannot make decisions that are different from what I have stated in this living will.

   _____ **(initial) Follow health care agent:** My health care agent has the authority to make decisions that are different from what I have indicated in this living will.

This form is not complete until notarized in Part C.

Part C: Completing this Document

My name is: _____ My birth date is: _____/_____ /_____
(Please Print)

1. Your Signature - STOP

(Note: Wait until two witnesses and a notary public are present before you sign.)

I am mentally alert and competent, and I am fully informed about the contents of this document.

Date: _____Signature: _____

2. Signatures of Witnesses

I hereby state that the person named above, _____, being of sound mind, signed (or directed another to sign on the person's behalf) the foregoing document in my presence. I am not related to the person by blood or marriage, and I would not be entitled to any portion of the estate of the person under any existing will or codicil of the person or as an heir under the law, if the person died on this date without a will. I am not the person's attending physician. I am not a licensed health care provider or mental health treatment provider who is (1) an employee of the person's attending physician or mental health treatment provider, (2) an employee of the health facility in which the person is a patient, or (3) an employee of a nursing home or any adult care home where the person resides. I do not have any claim against the person or the estate of the person.

Date: _____ Signature of Witness: _____

Date: _____ Signature of Witness: _____

3. Notarization

_____ COUNTY, _____ STATE

Sworn to (or affirmed) and subscribed before me this day by

_____ *(type/print name of Signer)*

_____ *(type/print name of Witness)*

_____ *(type/print name of Witness)*

Date: _____ Signature of Notary Public: _____
(Official Seal)

_____
(type/print name of Notary Public)

My commission expires: _____ *(date)*