DURABLE POWER OF ATTORNEY FOR HEALTHCARE
(DESIGNATION OF HEALTH CARE SURROGATE)

In the event that I, (name) ____________________ age________ have been determined by my physician(s) to be incompetent/incapacitated (lack the ability) to provide informed consent for medical treatment and surgical and diagnostic procedures including but not limited to the withholding, withdrawal, or continuation of life prolonging procedures, I wish to designate as my decisionmaker (surrogate) to make health care decisions:

Name: ______________________________ / ____________________ Phone# (w) ____________________
relationship
(h) ____________________

Address: ____

If my surrogate is unwilling or unable to perform his/her duties, I wish to designate as my alternate decisionmaker:

Name: ______________________________ / ____________________ Phone# (w) ____________________
relationship
(h) ____________________

Address: ____

I fully understand that this designation will permit my decisionmaker to make all health care decisions on my behalf until I regain the ability to make health care decisions. The healthcare decisions may also include if necessary the decisions to withhold, withdraw, or continue life prolonging procedures. My decisionmaker may also authorize my admission to or transfer from a health care facility and also apply for public assistance on my behalf. This designation is to remain in effect during any incapacity or incompetency I may experience.

Additional instructions (optional): ____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

1st Witness (required): ____________________ Signature: ____________________

2nd Witness (required): ____________________ Date: ____________________

LIVING WILL

I, (name) ____________________ willfully and voluntarily make known my desire that my dying **not** be prolonged under the following circumstances. If at any time I have a terminal condition and/or am in a persistent vegetative state, and if my attending/treating physician and a consulting physician have determined that there is no medical probability of my recovery from such condition(s), I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying. I request to be permitted to die naturally with only the administration of medication or the performance of medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I also desire to have life prolonging procedures withheld/withdrawn when: (optional)

______ Due to a debilitating disease condition in which I have no reasonable probability of recovering, I cannot
Initial communicate or interact purposely with others.

______ Specify Other Condition: ____
Initial

In addition, I do ____ or I do not ____ want to be given nutrition (food) and/or hydration (water) artificially by a feeding tube or by
Initial **Initial** intravenous feedings when it would serve only to prolong artificially the process of dying.

Additional instructions (optional): ____

I request that my Living Will be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

If I am pregnant and this is known to my physician(s), this Living Will shall have no force or effect during the course of my pregnancy.

I understand the full meaning of this Living Will, and I am emotionally and mentally competent to make these declarations.

1st Witness (required): ____________________ Signature: ____________________

2nd Witness (required): ____________________ Date: ____________________

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