INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your Agent the authority to make any and all health care decisions for you when you are no longer capable of making them yourself. "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your Agent therefore can have the power to make a broad range of health care decisions for you. Your Agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment.

You may state in this document any treatment you do not desire or treatment you want to be sure you receive. Your Agent's authority will begin when your doctor certifies that you lack the capacity to make health care decisions. You may attach additional pages if you need more space to complete your statement.

Your Agent will be obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your Agent will have the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care providers before you sign it to make sure that you understand the nature and range of decisions which may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as Agent should be someone you know and trust and must be at least 18 years old. If you appoint your health or residential care provider (e.g. your physician, or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person will have to choose between acting as your Agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want him or her to be your health care Agent. You should discuss this document with your Agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who will have signed copies. Your Agent will not be liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your Agent by informing him or her or your health care provider orally or in writing.

This document may not be changed or modified. If you want to make changes in the document you must make an entirely new one.

You may wish to designate an alternate Agent in the event that your Agent is unwilling, unable or ineligible to act as your Agent. Any alternate Agent you designate will have the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO (2) OR MORE QUALIFIED WITNESSES WHO MUST BOTH BE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

1. the person you have designated as your Agent;
2. your health or residential care provider or one of their employees;
3. your spouse;
4. your lawful heirs or beneficiaries named in your will or a deed;
5. creditors or persons who have a claim against you;
6. your reciprocal beneficiary.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

A. DESIGNATION OF AGENT. I, _____, hereby appoint:

Agent Name: _____

Address: _____

Relation, if any: _____

as my Agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions.

NOTICE: A person may not exercise the authority of an Agent while serving in one of the following capacities:

A. the Principal's health care provider;
B. nonrelative of the Principal who is an employee of the Principal's health care provider;
C. the Principal's residential care provider; or
D. a nonrelative of the Principal who is an employee of the Principal's residential care provider.

B. LIFE-SUSTAINING TREATMENT. If I suffer a condition from which there is no reasonable prospect of regaining the ability to think and act for myself, I want care directed to my comfort and dignity, and authorize my Agent to decline all treatment (including artificial nutrition and hydration) the primary purpose of which is to prolong my life.

C. LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT: None

D. DESIGNATION OF ALTERNATE AGENT. If the person designated as my Agent is not available or unable to act, I designate the following persons to serve as my Agent to make health care decisions from me as authorized by this document, who serve in the following order:

FIRST ALTERNATE AGENT

Agent Name: _____

Address: _____

E. NOMINATION OF GUARDIAN. If a Guardian of my person is to be appointed for me, I nominate my Agent (or Alternate Agent) to serve as my Guardian.

F. ACKNOWLEDGEMENT OF DISCLOSURE STATEMENT. 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 contained in the Disclosure Statement.

G. SEVERABILITY. If any provision in this document is held to be invalid, such invalidity shall not affect the other provisions which can be given effect without the invalid provision, and to this end the directions in this document are severable.

(YOU MUST DATE AND SIGN THIS DOCUMENT)

In witness whereof, I have hereunto signed my name this _____ day of _____, _____.

Signature: _____

Name: _____

Address: _____

STATEMENT OF WITNESSES

(The Durable Power of Attorney for Health Care shall be signed by _____, the "Principal," in the presence of at least two or more subscribing witnesses, neither of whom shall, at the time of execution, be the Agent, _____'s health or residential care provider or the provider's employee, _____'s spouse, heir, or reciprocal beneficiary, a person entitled to any part of the estate of _____ upon the death of _____ under a will or deed in existence or by operation of law or any other person who has, at the time of execution, any claims against the estate of _____.)

I declare that _____ 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 _____ has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

Witness Signature: _____

Name: _____

Address: _____

Date: _____

Witness Signature: _____

Name: _____

Address: _____

Date: _____