PROXY DIRECTIVE—(Durable Power of Attorney for Health Care)
Designation of Health Care Representative

I understand that as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction and they will turn to someone who knows my values and health care wishes. By writing this durable power of attorney for health care I appoint a health care representative with the legal authority to make decisions on my behalf and to consult with my physician and others. I direct that this document become part of my permanent medical records.

A) CHOOSING A HEALTH CARE REPRESENTATIVE:

I, ___________________________________ hereby designate __________________________________

Address: ____

Phone: _______________________________________

as my health care representative to make any and all health care decisions for me, including decisions to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining measures. I direct my representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear, my representative is authorized to make decisions in my best interest, based on what is known of my wishes.

This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations.

B) ALTERNATIVE REPRESENTATIVES: If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in the order of priority stated:

1. Name____

   Address____Phone___________________

2. Name____

   Address____Phone__________________

C) SPECIFIC DIRECTIONS: Please initial statement #1 or #2 which best expresses your wishes.

1. __________ My health care representative is authorized to direct that all life-sustaining procedures, including but not limited to CPR and artificially provided fluids and nutrition **BE WITHHELD OR WITHDRAWN** if I am ever, in the professional opinion of my physician and one other physician:
    a. Permanently unconscious or
    b. Terminally, incurably and irreversibly ill.

2. ___________ My health care representative does not have the authority in C #1 (above), and I direct that all life-sustaining procedures **BE PROVIDED** to preserve life, including but not limited to CPR, fluids and nutrition, to the extent medically appropriate, regardless of my physical and/or mental condition.

3. **In either case, I direct that I be kept comfortable as possible, which may require pain medication.**

4. Additional specific instructions concerning my health care:

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D) COPIES: The original or a copy of this document has been given to my health care representative and to the following:

1. Name____

   Address____

   Phone____

2. Name____

   Address____

   Phone____

E) SIGNATURE: By writing this durable power of attorney for health care, I inform those who may become entrusted with the care of my health care wishes and intend to ease the burdens of decision making which this responsibility may impose. I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with my wishes as expressed in this document and sign it knowingly, voluntarily and after careful deliberation.

Signature: ____

Date: ________________________

Address: ____

F) WITNESSES: I declare that the person who signed this document, or asked another to sign this document on his or her behalf did so in my presence, that he or she is personally known to me, and that he or she appears to be of sound mind and free of duress or undo influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative, nor as an alternate health care representative.

1. Witness name_______________________________________

   Address____

   Signature____

   Date_____________________

2. Witness name_______________________________________

   Address____

   Signature____

   Date_____________________