MEDICAL POWER OF ATTORNEY

1. DISCLOSURE STATEMENT

CAUTION TO THE "PRINCIPAL": YOUR MEDICAL POWER OF ATTORNEY IS AN IMPORTANT DOCUMENT. AS THE "PRINCIPAL", YOU GIVE THE PERSON WHOM YOU CHOOSE (YOUR "AGENT") AUTHORITY TO MAKE MEDICAL DECISIONS ON YOUR BEHALF. BEFORE SIGNING THIS DOCUMENT, READ THE INFORMATION CAREFULLY AND SEEK GUIDANCE FROM A PHYSICIAN OR AN ATTORNEY IF YOU DO NOT FULLY UNDERSTAND ANY OF THE FOLLOWING TERMS AND FACTS:

Your agent has the power to make a very broad range of medical decisions for you. Medical decisions can include any medical service, treatment, medical procedure, diagnosis or treatment of both your mental and physical conditions.

The person you choose as your agent must be at least eighteen years old or a person under 18 years of age who has had the disabilities of a minority removed. Your agent will have the authority to consent, and to refuse to consent to medical treatment according to your wishes, including decisions about withdrawing or withholding life-sustaining treatment, based on your religious and moral beliefs, when you are no longer capable of making them yourself. Therefore, it is important that the person you appoint as your agent is someone you trust. Your agent should also know your wishes or preferences for your health care treatment.

You should inform the person you wish to appoint as the agent that you want the person to be your health care agent. You should make sure that you have chosen an agent that wants to take on the role of agent. You should also discuss this document and your medical preferences with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. You may also choose a backup agent in case your other agent is unavailable to act. Your backup agent should also be aware of your preferences. Even after you sign this document, you will still be able to make your health care decisions assuming you are still considered mentally competent. Your agent cannot act on your behalf until your doctor certifies that you lack the competence to make health care decisions.

Your agent is not liable for health care decisions made in good faith on your behalf.

You may revoke the authority granted to your agent at any time while you are still competent to do so. The authority granted to your agent will be revoked when you tell your medical provider and your agent, orally or in writing, that you are revoking this medical power of attorney. If you execute another power of attorney later, that will also have the effect of revoking any prior power of attorney. Unless you state otherwise, your appointment of a spouse is revoked if your marriage is dissolved, annulled, or declared void.

In order for this document to be valid, it must be signed in accordance with the law of the state where you are signing this document. In general, the medical power of attorney should be signed in the presence of a notary or two witnesses. If you choose to have two witnesses sign, they must be at least 18 and competent. Neither of the two witnesses may be your agent or be related to your agent.

This document may not be changed or modified. If you want to make changes in the document, you must execute a new medical power of attorney.

2. DESIGNATION OF HEALTH CARE AGENT

I, ___________________*[PRINCIPAL NAME]*, appoint ___________________*[AGENT NAME]*, with a permanent residence at ___________________*[AGENT ADDRESS]* and phone number ______________ *[PHONE NUMBER]*, as my agent to make any and all health care decisions for me, except to the extent stated in this document. This medical power of attorney takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:
____
____
____
____.

3. DESIGNATION OF ALTERNATE AGENT

You are not required to designate an alternate agent. However, you may do so if you wish. An alternate agent may make the same health care decisions as to the designated agent if the designated agent is

unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved, annulled, or declared void unless the document provides otherwise.

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following person(s) to serve as my agent(s) to make healthcare decisions for me, as authorized by this document:

First Alternate Agent

Name: ___________________*[ALTERNATE AGENT NAME]*

Address: ___________________*[ALTERNATE AGENT ADDRESS]*

Phone: ___________________*[PHONE NUMBER]*

Second Alternate Agent

Name: ___________________*[ALTERNATE AGENT NAME]*

Address: ___________________*[ALTERNATE AGENT ADDRESS]*

Phone: ___________________*[PHONE NUMBER]*

Third Alternate Agent

Name: ___________________*[ALTERNATE AGENT NAME]*

Address: ___________________*[ALTERNATE AGENT ADDRESS]*

Phone: ___________________*[PHONE NUMBER]*

4. LIMITATIONS ON MY AGENT

My agent is authorized to make all medical decisions on my behalf, EXCEPT for the following:

____
____
____

____
_______________________________________.

5. DURATION

I understand that this power of attorney exists indefinitely from the date I execute this document or until the established end date is reached. However, I may revoke the power of attorney at any moment by notifying my agent orally or in writing. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted to my agent continues to exist until I become able to make healthcare decisions for myself.

[This power of attorney ends on the following date: _______________*MONTH]* _____*[DAY]*, _________*[YEAR]*].

6. REVOCATION OF PRIOR MEDICAL POWER OF ATTORNEY

I hereby revoke or terminate any and all medical power of attorney that have been previously signed by me.

7. ORIGINAL AND COPIES OF THIS MEDICAL POWER OF ATTORNEY

The original copy of this document is kept at:

Name/Institution: ____________________*[PERSON OR INSTITUTION NAME]*

Address: ____________________*[ADDRESS]*

Phone: ____________________*[PHONE NUMBER]*

The following individuals or institutions have signed copies of this document:

Name: ____________________*[PERSON OR INSTITUTION NAME]*

Address: ____________________*[ADDRESS]*

Name: ____________________*[PERSON OR INSTITUTION NAME]*

Address: __________________*[ADDRESS]*

The copies of this document are located at:

Name/Institution: _________________*[PERSON OR INSTITUTION NAME]*

Address: __________________*[ADDRESS]*

Phone: __________________*[PHONE NUMBER]*

Name/Institution: _________________*[PERSON OR INSTITUTION NAME]*

Address: __________________*[ADDRESS]*

Phone: __________________*[PHONE NUMBER]*

8. EXECUTION

YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES NOT RELATED BY BLOOD OR MARRIAGE.

9. VALIDITY

THIS MEDICAL POWER OF ATTORNEY IS NOT VALID UNLESS:

1. YOU SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC; OR

2. YOU SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.

10. WITNESS INSTRUCTIONS

THE FOLLOWING PERSONS MAY NOT ACT AS ONE OF THE WITNESSES:

1. The person you have designated as your agent;

2. A person related to you by blood or marriage, domestic partnership or adoption, nor a spouse of any such person;

3. A person entitled to any part of your estate after your death under a will or codicil executed by you or by operation of law;

4. Your attending physician, including the owner or operator of a healthcare facility, short-term or long-term care, or other residential or community care facility serving you;

5. An employee of your attending physician or healthcare provider;

6. An employee of a health care facility in which you are a patient if the employee is providing direct patient care to you or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or 7. A creditor of yours or entitled to any part of your estate under a will or codicil, trust, insurance policy, or by operation of intestate succession laws.

8. A person financially responsible for your health care;

9. An employee of your life or health insurance provider;

10. A person entitled to benefit financially in any other way after you die.

By signing below, I acknowledge that I have read and understand the information contained in the above disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC OR YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES.)

11. SIGNATURE AND NOTARY ACKNOWLEDGMENT

I sign my name to this medical power of attorney on this ___________________*[DATE]* day of ___________________*[MONTH]*, ___________________*[YEAR]* at ___________________*[CITY]*, ___________________*[STATE]*.

STATE OF ________________________ ___________________________________

COUNTY OF ____________________*[COUNTY]* *[PRINCIPAL NAME]*

Before me, the undersigned authority, on this day personally appeared ___________________________ *[PRINCIPAL NAME]*, known to me [or proved to me on the oath of __________________*[NAME]* or through (description of identity card or other document) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that [he/she] executed the same for the purpose and consideration therein expressed.

Given under my hand and seal of office this__________________ *[DATE]* day of __________________*[MONTH]*, __________________*[YEAR]*.

____

Notary Public, State of _________

My commission expires: ________

____

OR

12. SIGNATURE AND NOTARY ACKNOWLEDGMENT

I sign my name to this medical power of attorney on this __________________*[DATE]* day of ___________*[MONTH]*, ________*[YEAR]* at __________________*[CITY]*, ____________*[STATE]*.

____

[PRINCIPAL NAME]

13. STATEMENT AND SIGNATURE OF FIRST WITNESS

I am not the person appointed as agent by this document. I am not related to the principal by blood or marriage. I would not be entitled to any portion of the principal's estate on the principal's death. I am not the attending physician of the principal or an employee of the attending physician. I have no claim against any portion of the principal's estate on the principal's death. Furthermore, if I am an employee of a healthcare facility in which the principal is a patient, I am not involved in providing direct patient care to the principal and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

Name: __________________*[FIRST WITNESS NAME]*

Address: __________________*[FIRST WITNESS ADDRESS]*

Phone: __________________

Signature:___________________________________ DATE:____________

SIGNATURE OF SECOND WITNESS

Name: __________________*[SECOND WITNESS NAME]*

Address: __________________*[SECOND WITNESS ADDRESS]*

Phone: __________________

Signature:___________________________________ DATE:____________