DECLARATION
and
POWER OF ATTORNEY FOR HEALTH CARE

I. DECLARATION

This Declaration is made this _____ day of _____.
I, _____, being of sound mind, willfully and voluntarily state as follows:

A. LIFE-SUSTAINING TREATMENT. If I should lapse into a persistent vegetative state, or have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Rights of the Terminally Ill Act, to withhold or withdraw life-sustaining treatment that is not necessary for my comfort or to alleviate pain.

B. NUTRITION AND HYDRATION. If I have a state or condition stated above, it is my preference TO RECEIVE artificially administered nutrition and hydration (food and fluids).

II. POWER OF ATTORNEY FOR HEALTH CARE

A. DESIGNATION OF HEALTH CARE AGENT. I appoint:

Agent Name: _____

Address: _____
_____

Phone: Home: _____ Work: _____
Relation, if any: _____

as my Attorney-in-Fact ("Agent") for Health Care. I authorize my Attorney-in-Fact appointed by this document to make health care decisions for me when I am determined to be incapable of making these health care decisions on my own. I fully understand the consequences of executing a Power of Attorney for Health Care.

None of the following may serve as your Attorney-in-Fact:

(1) Your attending physician;
(2) An employee of your attending physician who is not related to you by blood, marriage, or adoption;
(3) A person not related to you by blood, marriage, or adoption who is an owner, operator, or employee of a health care provider in or of which you are a patient or resident; and
(4) A person not related to you by blood, marriage, or adoption if, at the time of the proposed

designation, he or she is personally serving as an Attorney-in-Fact for ten or more Principals.

B. CREATION OF POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a Power of Attorney for Health Care. This document shall take effect when I am incapable of making health care decisions for myself. In other words, my Agent shall have the authority to make health care decisions for me if I am unable to understand and appreciate the nature and consequences of health care decisions, including the benefits of, risks of, and alternatives to proposed health care or I am unable to communicate in any manner regarding any informed health care decision. This power of attorney shall continue during any period of my incapacity.

C. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I grant to my Agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so.

In exercising this authority, my Agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my Agent. If my desires regarding a particular health care decision are not known to my Agent, then my Agent shall make the decision for me based upon what my Agent believes to be in my best interests. I specifically grant to my Agent the authority to consent to the withholding or withdrawing of life-sustaining procedures, as permitted by law, but NOT including the provision of artificially administered nutrition and hydration.

III. GENERAL PROVISIONS

A. HOLD HARMLESS. All persons or entities who in good faith endeavor to carry out the terms and provisions of this document shall not be liable to me, my estate, my heirs or assigns for any damages or claims arising because of their action or inaction based on this document, and my estate shall defend and indemnify them.

B. SEVERABILITY. If any provision of 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.

C. STATEMENT OF INTENTIONS. It is my intent that this document be legally binding and effective. If the law does not recognize this document as legally binding and effective, it is my intent that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period in which I am unable to make such decisions.

I HAVE READ THIS DOCUMENT. I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY ATTORNEY IN FACT, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT. I ALSO UNDERSTAND THAT I CAN REQUIRE IN THIS POWER OF ATTORNEY FOR HEALTH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

Signed on _____ day of _____.

Signature: _____

Name: _____
Address: _____
_____

State of _____
County of _____

On this _____ day of _____, before me _____, a notary public in and for _____ County, personally came _____, personally to me known to be the person whose name is affixed to the above power of attorney for health care as principal, and I declare that he or she appears in sound mind and not under duress or undue influence, that he or she acknowledges the execution of the same to be his or her voluntary act and deed, and that I am not the attorney in fact or successor attorney in fact designated by this power of attorney for health care.

Witness my hand and notarial seal at _____ in such county as the day and year written above.

Seal: _____
Signature of Notary Public