Durable Power of Attorney for Health Care Form

Designation of Health Care Agent

I, _____appoint:

Name: _____

Address: _____

_____

Phone: _____
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 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:

_____

_____

_____

Designation of Alternate Agent

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as 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.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. **First Alternate Agent**

Name: _____

Address: _____

_____

Phone: _____

B. **Second Alternate Agent**

Name: _____

Address: _____

_____

Phone: _____

The original of this document is kept at____

_____

The following individuals or institutions have signed copies:

Name: _____

Address: _____

_____

Name: _____

Address: _____

_____

Duration

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney ends on
the following date: _____

Prior Designations Revoked

I revoke any prior Durable Power of Attorney for Health Care.

Acknowledgment of Disclosure Statement

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Durable Power of Attorney for Health Care on

_____ day of _____ 19_____

at_____.
(City and State)

_____
(Signature)

_____
(Print Name)

Statement of Witness

I declare under penalty of perjury that the principal has identified himself or herself to me, that the principal signed or acknowledged this Durable Power of Attorney in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, that I am not the person appointed as agent by this document, and that I am not a provider of health or residential care, an employee of a provider of health or residential care, the operator of a community care facility, or an employee of an operator of a health care facility.

I declare that I am not related to the principal by blood, marriage, or adoption and that to the best of my knowledge I am not entitled to any part of the estate of the principal on the death of the principal under a will or by operation of law.

Witness Signature: _____

Print Name: _____

Address: _____

_____

Date: _____

Witness Signature: _____

Print Name: _____

Address: _____

_____

Date: _____