SAMPLE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Remember – this is a guide only. Each state has different requirements so check your state and the recommended online legal services outlined in this chapter. This sample uses some information from Rocket Lawyer.

DESIGNATION OF HEALTH CARE AGENT. I, (Name)_____

of (County)_____

appoint:

Agent Name

Address:

Phone: Home: Cell:

Relation, if any:

as my Agent to make health care and personal decisions for me if I become unable to make such decisions for myself, except to the extent I state otherwise in this document.

NOTICE: The following individuals may not act as your health care Agent:

(1) Any of your physicians;

(2) An employee of any of your physicians;

(3) Owners, administrators, or employees of the health care facility where you reside or receive care.

Unless the above person is your spouse, adult child, brother, or sister.

B. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

By this document I intend to create a Durable Power of Attorney for Health Care. This power of attorney shall take effect upon my disability, incapacity, or incompetency, and shall continue during such disability, incapacity, or incompetency.

C. **GENERAL STATEMENTOF 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, including the power to direct the withdrawal or withholding of artificially provided food and nutrition. In making any decision, my Agent shall attempt to

discuss the proposed decision with me to determine my desires if I am able to communicate in any way. In addition, my Agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to myAgent.

D. LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT:

This is an example of a limitation you can have.

I wish to limit my Agent's authority to allow artificial life-prolonging treatments, ie. breathing machines, in the event of a terminal illness.

E. **AUTOPSY, ANATOMICAL GIFTS, DISPOSITION OF REMAINS.** I authorize my Agent, to the extent permitted by law, to make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains.

F. **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 healthcare decisions for me as authorized by this document, who serve in the following Corder:

FIRST ALTERNATE AGENT

Agent Name:

Address:

Phone: Home:

G. **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.

H. GENERAL PROVISIONS.

1. **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.

2. **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.

3. **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.

(NOTE: YOU MUST DATE AND SIGN ANY POWER OF ATTORNEY FORM FOR IT TO BE LEGAL)

I have read and understand the contents of this document and the effect of this grant of powers to my Agent. I am emotionally and mentally competent to make this declaration.

Signed on _____day of _____, _____.

Signature: _____

Name:

Address:

Birthdate:

READ CAREFULLY AND FOLLOW THE WITNESSING PROCEDURE. IT REQUIRES TWO WITNESSES AND A NOTARY TO FORMALIZE THIS DOCUMENT.

STATEMENT OF WITNESSES

I declare that (Insert Your Name) who signed or acknowledged this document (the "Principal") has identified himself or herself to me, that (Insert Name) signed or acknowledged this document in my presence, that (Insert Name) appears to be of sound mind, and under no duress, fraud, or undue influence. I am not the person appointed as Agent or Alternate Agent by this document, nor am I 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 further declare that I am not related to (Insert Your Name) by blood, marriage, or adoption, and to the best of my knowledge, I am not a creditor of (Insert Your Name) or entitled to any part of the estate of (Insert Your Name) under a will now existing or by operation of law.

Witness Signature: _____

Name: _____Address: _____

_____

Date: _____

Witness Signature: _____

Name: _____Address: _____
_____ Date: _____

STATE OF

COUNTY OF

NOTARY PUBLIC STATEMENT

On this day personally appeared before me (INSERT NAME), to me known to be the individual described in and who executed the within and foregoing instrument, and acknowledged that he/she signed the same as his/her free and voluntary act and deed for the uses and purposes therein mentioned.

Given under my hand and official seal this _____day of _____,_____.

My commission expires: _____

NOTARY PUBLIC in and for the State of (INSERT STATE)

residing at