Medical Power of Attorney Designation of Health Care Agent

| I, | (insert your name) appoint: |
|------------------------|--|
| Nam | e: |
| Addr | ess: |
| Phon | e: |
| exter effec | y agent to make any and all health care decisions for me, except to the nt I state otherwise in this document. This Medical Power of Attorney takes t when I become unable to make my own health care decisions and this is certified in writing by my physician. |
| | TATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS OWS: |
| Desi | gnation of Alternate Agent |
| do so desig agen | are not required to designate an alternate agent or agents, but you may b. An alternate agent may make the same health care decisions as the gnated agent if the designated agent is unable or unwilling to act as your t. If the agent designated is your spouse, the designation is automatically ked by law if your marriage is dissolved.) |
| care to ma | e person designated as my agent is unable or unwilling to make health decisions for me, I designate the following persons to serve as my agent ake health care decisions for me as authorized by this document, who in the following order: |
| A. | First Alternate Agent |
| | Name: |
| | Address: |
| | Phone: |
| В. | Second Alternate Agent |
| | Name: |
| | Address: |
| | Phone: |

| | The original of this document is kept at: | | |
|-----|---|--|--|
| | | | |
| The | following individuals or institutions have signed copies in their possession: | | |
| | 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 Medical Power of Attorney.

Acknowledgment of Disclosure Statement

I have been provided with a Disclosure Statement explaining the effect of this document. I have read and understand the information contained in the Disclosure Statement.

(You must date and sign this Medical Power of Attorney to make it effective. You have two options. The first option is to sign and have it acknowledged before a notary public. The second is to sign before two witnesses who also sign. The first witness must meet the requirements described later.)

(First Option Before a Notary)

| I sign my name to this Medical Power of Attorney on day of | | |
|--|---|--|
| | (month, year) at | |
| | (City and State) | |
| - | (Signature) | |
| | (Print Name) | |
| State of Texas County of | | |
| This instrument was a by | cknowledged before me on (date) (name of person acknowledging). | |
| | NOTARY PUBLIC, State of Texas Notary's printed name: | |
| | My commission expires: | |
| | OR | |
| (Second Option Befo | ore Two Competent Witnesses) | |
| I sign my name to this | s Medical Power of Attorney on day of (month, year) at | |
| | (City and State) | |
| | (Signature) | |
| | (Print Name) | |

Statement and Qualifications 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 health care 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.

| Signature: | | | | |
|---|-------|--|--|--|
| Print Name: | Date: | | | |
| Address: | | | | |
| Signature of Second Witness Signature: | | | | |
| Print Name: | | | | |
| Address: | | | | |