: _____ : _____

: _____ _____

This portion of my Advance Directive creates a durable power of attorney for healthcare. This power of attorney will remain in effect if I become incapacitated and shall be effective when I am unable to communicate and lack decisional capacity.

For the purposes of this Directive, "healthcare decision" means:

- Consent
- Refusal of consent; or
- Withdrawal of consent

to any care, treatment, or procedure to maintain, diagnose or treat an individual's medical condition.

1. . I designate and appoint the following individual as my healthcare agent to make healthcare decisions for me as authorized in this Directive:

Name of Healthcare Agent: _____

Telephone Number of Healthcare Agent: _____

Address: _____

2. . If the person designated as my healthcare agent in paragraph 1:

- Is not available or becomes ineligible to act as my agent to make a healthcare decision for me; or
- Loses the mental capacity to make healthcare decisions for me; or
- If I revoke that person's designation or authority to act as my agent to make healthcare decisions for me,

then I designate and appoint the following person to serve as my agent to make healthcare decisions for me as authorized in this Directive (Y*ou are not required to designate any alternate agents, but you may do so. Any alternate agent you designate will be able to make the same healthcare decisions as the agent you designated in paragraph 1 above, in the event that person is unable or ineligible to act as your agent.)*

A. Name of First Alternate Healthcare Agent: _____

Telephone Number: _____

Address: _____

B. Name of Second Alternate Healthcare Agent: _____

Telephone Number: _____

Address: _____

This Advance Directive states my choices about life-sustaining medical treatment at the end of life. This Directive shall be effective only if I am unable to communicate my instructions and:

The following are additional statements of my wishes. *Check all boxes that apply and initial on the line after such box:*

_____ If I have a medical condition from which I am not imminently dying, and from which I will not likely recover, am unable to think or communicate and am dependent on others for my care, I do not want life-sustaining medical treatment or procedures to be started. If already started, I want all such treatment and procedures to be withdrawn, including withdrawal of artificial nutrition (such as feeding tube) and artificial hydration (such as IV). In such condition, I want care to be focused on my comfort.

_____ Other situations as described in the box below *(If needed, attach and sign additional pages):*

Some examples of things that may be included here are: no admission to Intensive Care Unit; resuscitation preference*; willingness to live permanently in a nursing home; people you do not want involved in your medical decisions; limitations to treatment options, including time limits; willingness to have a permanent feeding tube; funeral and burial wishes; organ/body donation, etc.

**NOTE: If you wish to be DNR (Do Not Resuscitate), you must complete a POST form. Ask your physician, advanced practice nurse or physician assistant to complete a POST form with you. A POST form contains specific medical orders for individuals with a serious illness.*

<u>Check one box</u> and initial the line after the box you checked:

_____ I have completed a Physician Orders for Scope of Treatment (POST) form that contains directions that may be more specific than, but are compatible with,