Durable Power of Attorney for Health Care

Declaration of a Durable Power of Attorney for Health Care Only

1. Declaration.

A. Life Sustaining Procedures. Declaration made on this date, _____, I, _____ ("Declarant"), being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition or a permanently unconscious condition by two (2) physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized, or that I will remain in a permanently unconscious condition, and where the application of life-sustaining procedures would serve only to prolong artificially the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary to provide me with comfortable care.

B. Hydration and Nutrition. I realize that situations could arise in which the only way to allow me to die would be to discontinue artificial nutrition and hydration. In carrying out any instruction I have given under this section, I authorize that artificial nutrition and hydration BE STARTED, or if started, BE CONTINUED.

C. Pregnancy. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this document shall have no force or effect during the course of my pregnancy. However, if at any point it is determined that it is not possible that the fetus could develop to the point of live birth with continued application of life-sustaining procedures, it is my preference that this document be given effect at that point. If life-sustaining procedures will be physically harmful or unreasonably painful to me in a manner that cannot be alleviated by medication, I request that my desire for personal physical comfort be given consideration in determining whether this document shall be effective if I am pregnant.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this Declaration shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

2. Declaration of Health care Agent. I, the Declarant, hereby appoint: _____ ("Agent") as my Agent to make any and all health care decisions for me, except to the extent I state otherwise in this document or as prohibited by law. My agent must act consistently with my desires as stated in this document or otherwise made known. This Durable Power of Attorney for Health Care shall take effect in the event I become unable to make my own health care decisions.

3. Statement of Desires, Special Provisions, and Limitations regarding Health Care Decisions and Options. I give my Agent power to act in these specified circumstances: If I become permanently incompetent to make health care decisions, and if I am also suffering from a

terminal illness, I authorize my Agent to direct that life-sustaining treatment be discontinued. Whether terminally ill or not, if I become permanently unconscious I authorize my Agent to direct that life-sustaining treatment be discontinued. I realize that situations could arise in which the only way to allow me to die would be to discontinue artificial feeding (artificial nutrition and hydration). In carrying out any instructions I have given in this power of attorney, I authorize my Agent to direct that artificial nutrition and hydration not to be started or, if started, be discontinued.

4. Designation of an Alternate Agent. In the event the person I appoint above is unable, unwilling or unavailable, or ineligible to act as my Health Care Agent, I hereby appoint the following persons as Alternate Agent:

First Alternate Agent

Agent Name:
Address:
Phone: Home: Work:

Second Alternate Agent

Agent Name:
Address:
Phone: Home: Work:

5. Other Provisions. I hereby acknowledge that 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. I understand the full import of this Declaration and Durable Power of Attorney for Health Care and I am emotionally and mentally competent to make this Declaration and Durable Power of Attorney for Health Care.

6. Notices.

Any notice required by this Agreement or given in connection with it, shall be in writing and shall be given to the appropriate party by personal delivery or a recognized over night delivery service such as FedEx.

If to the Declarant: _____.

If to My Physician: _____.

7. No Waiver.

The waiver or failure of either party to exercise in any respect any right provided in this Agreement shall not be deemed a waiver of any other right or remedy to which the party may be entitled.

8. Entirety of Agreement.

The terms and conditions set forth herein constitute the entire agreement between the parties and supersede any communications or previous agreements with respect to the subject matter of this Agreement. There are no written or oral understandings directly or indirectly related to

this Agreement that are not set forth herein. No change can be made to this Agreement other than in writing and signed by both parties.

9. Governing Law.

This Agreement shall be construed and enforced according to the laws of the State of _____ and any dispute under this Agreement must be brought in this venue and no other.

10. Headings in this Agreement

The headings in this Agreement are for convenience only, confirm no rights or obligations in either party, and do not alter any terms of this Agreement.

11. Severability.

If any term of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, then this Agreement, including all of the remaining terms, will remain in full force and effect as if such invalid or unenforceable term had never been included.

In Witness whereof, the parties have executed this Agreement as of the date first written above.

_____ _____

Declarant My Physician

_____

Date

We, the following witnesses, being duly sworn, each declare to the notary public or justice of the peace or other official signing below as follows:

1. Declarant affirmed that he or she is aware of the nature of the document and signed the instrument as a free and voluntary act for the purposes expressed, or expressly directed another to sign for him or her.

2. Each witness signed at the request of Declarant, in his or her presence, and in the presence of the other witness.

3. To the best of my knowledge, at the time of the signing, Declarant was at least 18 years of age, and was of sane and sound mind and under no constraint, duress, or undue influence.

4. Neither of the undersigned witnesses is (i) Declarant's spouse, or (ii) Declarant's attending physician, or person acting under the direction or control of the attending physician or any other person who has a claim against Declarant's estate.

_____
Witness Signature:

Name:
Address:

_____
Witness Signature:

Name:
Address:

State of New Hampshire
County of

The foregoing instrument was acknowledged before me this Date: _____.

_____
Notary Public or Justice of the Peace
My Commission Expires: _____.

Copy List: Must include Physician; list them here: _____.

Durable Power of Attorney for Health Care
Review List

This review list is provided to inform you about the document in question and assist you in its preparation. This is literally a “life and death” issue for you. Treat it seriously accordingly. You are turning your fate over to others, if you elect to sign it.

Except to the extent you state otherwise, this document gives the person you name as your Agent the authority to make any and all health care decisions for you when you are no longer capable of making them yourself. "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your Agent, therefore, can have the power to make a broad range of health care decisions for you. Your Agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your Agent cannot consent or direct any of the following: commitment to a state institution, sterilization, or termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy unless the failure to withhold the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may modify this document to indicate any treatment you do not desire, except as stated above, or treatment you want to be sure you receive. Your Agent's authority will begin when your doctor certifies that you lack the capacity to make health care decisions. If for moral or religious reasons you do not wish to be treated by a doctor or examined by a doctor for the certification that you lack capacity, you must say so in the document and name a person to be able to certify your lack of capacity. That person may not be your Agent or Alternate Agent or any person ineligible to be your Agent.

If you want to give your Agent authority to withhold or withdraw the artificial providing of nutrition and fluids, your document must say so. Otherwise, your Agent will not be able to direct that. Under no conditions will your Agent be able to direct the withholding of food and drink for you to eat and drink normally.

Your Agent will be obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your Agent will have the same authority to make decisions about your health care as you would have had if made consistent with state law. If any of the above concerns you, don’t sign the document.

It is important that you discuss this document with your physician or other health care providers, as well as your lawyer, before you sign it to make sure that you understand the nature and range of decisions, which may be made, on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions.

The person you appoint as your Agent should be someone you know and trust and must be at least 18 years old. If you appoint your health or residential care provider (e.g., your physician, or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person will have to choose between acting as your Agent or as your health or residential care provider; the law does not permit a person to do both at the same

time, for obvious reasons to protect your own interests.

You should consult the individual you would like to appoint in advance of signing this document so that they can affirmatively tell you the will be willing to undertake this possible life and death responsibility to act as your Health Care Agent. If they elect to not undertake this responsibility, thank them and find another prospect Agent and repeat the process until you find someone willing to act in this serious capacity on your behalf. Whatever you do, do not surprise someone with this responsibility. You should discuss this document with your agreed upon Agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions that will have signed copies. Your Agent will not be liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your Agent by informing him or her or your health care provider orally or in writing. If you get cold feet later, we have provided a revocation document in this Agreement. You may revoke the Agreement just to appoint another Agent, as circumstances dictate or your life or their life changes to make it inappropriate for them to act on your behalf.

We strongly recommend you appoint someone significantly younger than yourself as Agent, if you elect to sign this Agreement, to avoid, or at least increase the odds, of them predeceasing you or having serious health problems themselves which would prohibit them acting appropriately on your behalf.

This document may not be changed or modified. If you want to make changes in the document you must make an entirely new one. This includes, but is not limited to, appointing a new Agent as discussed above.

You should consider designating an Alternate Agent in the event that your Agent is unwilling, unable, unavailable, or ineligible to act as your Agent. Any Alternate Agent you designate will have the same authority to make health care decisions for you

This power of attorney will not be effective unless signed in the presence of 2 or more qualified witnesses. The following people may not act as witnesses: the nominated Agent or Alternate Agent; your spouse; any lawful heirs or beneficiaries named in your will or deed. Only one of the two witnesses may be your related in any way or capacity to your health or residential care provider for obvious conflict of interest reasons and your personal protection by the law and statute.

Many states require that each provision be separately initialed. Since this has become the standard, you should consider it an absolute requirement to initial each and every paragraph, or sign it in full, if you so prefer.

To be on the safe side, initial each and every page of this document to prevent page substitution and prevent that assertion being made in any court of law. In addition, indicate who is on the copy list so those copies are accounted for, and, if necessary, can be retrieved for purposes of authentication, modification, or revocation.

<u>Reasons for an Update or Revocation</u>

1. You change your mind for any reason whatsoever.

2. You learn you have a terminal condition after signing this health care directive. This will provide an opportunity to restate or change your wishes in light of your new health status.

3. Change or set limits on the medical care that is provided.

4. Respond to a changing medical technology.

5. Respond to a change in health care laws.

6. Respond to a change in health, including pregnancy.

7. Life circumstances suggest appointing a different Agent.

8. Many more. Do not be reluctant to modify this Agreement should you so desire.

We strongly recommend you speak to your lawyer and clergyman about these decisions to be sure you are comfortable with them. This is literally a “life and death” situation. It bears serious discussion with those you trust most.