DURABLE POWER OF ATTORNEY FOR HEALTH CARE CHOICES & HEALTH CARE CHOICES DIRECTIVE

6-PAGE FORM

Part I. Durable power of attorney for health care choices

I, _____, _____,
Name Social Security number

appoint

_____, _____,
Name Phone

_____
Address

as my agent for health care choices when I am unable to make decisions or communicate my wishes. In the case the person above cannot serve as my agent, or if I am divorced from or legally separated from the agent above, I appoint the person below:

_____, _____,
Name Phone

_____
Address

This alternate agent may make health care decisions for me when I am unable to do so or to communicate my wishes.

This durable power of attorney becomes effective when **two** physicians certify that I am incapacitated and unable to make and communicate health care choices.

You may choose to have one physician, instead of two, determine whether you are incapacitated. If you want to exercise this option — allowing one physician to determine whether you are incapacitated — initial here.

By completing this durable power of attorney, I authorize my agent to make all decisions for me regarding my health care. This includes the power to withdraw any type of health care, treatment or procedure, even if I may die in the process. I expect my agent to follow my health care choices directive. My agent has the power to:

- Consent, refuse or withdraw consent to artificially supplied nutrition and hydration.
- Make all necessary arrangements for health care on my behalf. This includes admitting me to any hospital, psychiatric treatment facility, hospice, nursing home or other health care facility.
- Hire or fire health care personnel on my behalf.
- Request, receive and review my medical and hospital records.
- Take legal action if necessary to do what I have directed.
- Carry out my wishes regarding autopsy and organ donation, and decide what should be done with my body.

My agent under this durable power of attorney will not incur any personal financial liability. The agent also should not be compensated for services performed for me. However, the agent shall be reimbursed for reasonable expenses that are part of my care.

THIS IS A DURABLE POWER OF ATTORNEY AND THE AUTHORITY OF MY ATTORNEY IN FACT, WHEN EFFECTIVE, SHALL NOT TERMINATE OR BE VOID OR VOIDABLE IF I AM OR BECOME DISABLED OR INCAPACITATED OR IN THE EVENT OF LATER UNCERTAINTY AS TO WHETHER I AM DEAD OR ALIVE.

Part II. Health care choices directive

I want those involved in my health care to understand my wishes if I cannot communicate or make decisions on my own. I make this directive to provide clear and convincing proof of my wishes and instructions about my health care and treatment.
If my doctor believes medical treatment will lead to my recovery, I want to have the treatment. I also want to have care and treatment for pain or discomfort even if this treatment might shorten my life, affect my appetite, slow my breathing or be habit-forming.

If I have a terminal illness or condition and there is no reasonable hope I will recover, or if I am persistently unconscious, I direct all of the life-prolonging procedures I have initialed below to be withheld or withdrawn.

I direct the following treatments to be withheld or withdrawn:

- ☐ Surgery or other invasive procedures
- ☐ Cardiopulmonary resuscitation (CPR) to restart my heart or breathing
- ☐ Antibiotics
- ☐ Dialysis
- ☐ Mechanical ventilator (respirator)
- ☐ Artificially supplied nutrition and hydration (including tube feeding)
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ All other "life-prolonging" medical treatments or surgeries that are merely intended to keep me alive without reasonable hope of making me better or curing my illness or injury.
- ☐ I consent to the donation of my organs or tissues. I realize my body may need to be maintained artificially after my death until my organs can be removed.
- ☐ I refuse to make anatomical gifts of part or all of my body. I prohibit my agent from consenting to such gifts before or after my death.

I also give the following directions regarding my health care:

_____

_____

_____

_____

_____

_____

Optional: Describe what you consider an acceptable quality of life. For example, being able to recognize my loved ones, make decisions, communicate or feed yourself.

_____

_____

_____

_____

_____

_____

Attach extra pages if necessary. Sign and date the attached pages.

Make sure to talk about this directive and your wishes with your agent, your doctors, family, friends and clergy. Give each of them a copy of the directive. Bring a copy with you when you go to a hospital or other health care facility. Keep the original with your important papers.

Part III. Relationship between health care choices directive and durable power of attorney for health care choices

As I have executed the health care choices directive and durable power of attorney for health care choices, I trust and encourage my agent to:

- First, follow my wishes as expressed in the directive or otherwise from knowledge about me or having had discussions with me about making choices regarding life-prolonging medical treatment.
- Second, if my agent does not know my wishes for a specific decision, but my agent has evidence of what I might want, my agent can try to figure out how I would decide. This is called substituted judgment and requires my agent imagining himself or herself in my position. My agent should consider my values, religious beliefs, past choices and past statements I have made. The aim is to choose as I probably would choose, even if it is not what my agent would choose for himself or herself.
- Third, if my agent has very little or no knowledge of what I would want, then my agent and the doctors will have to make a decision based on what a reasonable person in the same situation would decide. This is called making decisions in my best interest. I have confidence in my agent's ability to make decisions in my best interest if my agent does not have enough information to follow my preferences or use substituted judgment, and if this is the case, I authorize my agent to make decisions that might even be contrary to my directive in his or her best judgment.
- Finally, if the durable power of attorney for health care choices is determined to be ineffective, or if my agent is unable to serve, the health care choices directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE & HEALTH CARE DIRECTIVE

Sign this form before two witnesses who are not related to you or financially connected to your estate.

IN WITNESS THEREOF, I have executed this document on _____ (MONTH) ____ (DAY), _____ (YEAR).

Signature _____

Print name _____ SS No._____

Address _____

The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses is at least 18 years of age.

Signature _____ Signature _____

Print name _____ Print name _____

Address _____ Address _____

_____ _____

Notarization required

STATE OF MISSOURI)
) SS
COUNTY OF _____)

On this ____ day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed.

IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of _____, State of Missouri, the day and year first above written.

_____
Notary public's signature