MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS OF

_____

I, _____, hereby appoint: _____ *(Name)*
Address: _____
_____
Phone: _____

as my agent to make health care decisions for me if and when I am unable to make my own health care decisions. This gives my agent the power to consent to giving, withholding or stopping any health care treatment, service or diagnostic procedure. My agent also has the authority to talk with health care personnel, get information and sign forms necessary to carry out those decisions. My agent also has the authority to employ or discharge health care personnel on my behalf. If for any reason _____ is unable or unwilling to so serve, then I appoint in their place, _____

By this document, I intend to create a Medical Durable Power of Attorney which shall take effect upon my incapacity to make my own health care decisions and shall continue during that incapacity. My agent shall make health care decisions as I may direct below or as I make known to them in some other way. If I have not expressed a choice about the health care in question, my agent shall base their decision on what they believe to be in my best interest. No person who relies in good faith on the authority of my agent under this document shall incur any liability to me, my estate or my heirs.

As a statement of desires concerning life-prolonging care, treatment, service and procedures:

I direct that no heroic or unusual prolonged treatment after hope of recovery is gone, and regular medical treatment, as well as emergency treatment have failed.

I sign this document as my free and voluntary act, in full awareness of its importance and effect.

Date: _____ _____ *[Signature]*
_____ *[Print Name]*

Witnesses:
I declare that _____, who signed and acknowledged this document, is personally known to me, and they signed this document in my presence on the _____ day of _____, 20____, and that they are of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as the agent in this document, nor am I the patient's health care provider, or an employee of the patient's health care provider.

_____ _____
Witness Witness
Address _____ Address _____
_____ _____
_____ _____

At least one of the witnesses must also make the following declaration:

I further declare that I am not related to _____ by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of their estate under a will now existing or by operation of law.

_____	_____
Witness	Witness
Address _____	Address _____
_____	_____
_____	_____

Subscribed, sworn to and acknowledged before me by _____, and subscribed and sworn to before me, by _____, and _____ , witnesses, this _____ day of _____, 20____.

Witness by my hand and official seal.
My commission expires: _____.

_____
Notary Public
Address _____
_____
_____