ADVANCE DIRECTIVE (Optional Form)

APPOINTMENT OF HEALTH CARE AGENT

(If you want to appoint an agent, cross through any items on the form that you do not want to apply.)

1. I, _____, residing at _____ appoint the following individual as my agent to make health care decisions for me:

_____
(Full Name, Address and Telephone Number of Agent)

Optional: If my agent named by me shall die, become legally disabled, incapacitated or incompetent, or resign, refuse to act, or be unavailable, I name the following as my alternate agent:

_____
(Full Name, Address and Telephone Number of Agent)

2. My agent has full power and authority to make health care decisions for me, including the power to:

a. Request, receive, and review any information, oral or written, regarding my physical or mental health, including but not limited to, medical and hospital records, and consent to the disclosure of this information.

b. Employ and discharge my health care providers;

c. Authorize my admission to or discharge from (including transfer to another facility) any hospital, hospice, nursing home, adult home, or other medical care facility; and

d. Consent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life-sustaining procedures.

3. The authority of my agent is subject to the following provisions and limitations:

_____
_____
_____

4. If I am pregnant, my agent shall follow these specific instructions:

_____
_____
_____

5. My agent's authority becomes operative (Initial the option that applies):

_____ When my attending physician and a second physician determine that I am incapable of making an informed decision regarding my health care; or

_____ When this document is signed.

6. My agent is to make health care decisions for me based on the health care instructions I give in this document and on my wishes as otherwise known to my agent. If my wishes are unknown or unclear, my agent is to make health care decisions for me in accordance with my best interest, to be determined by my agent after considering the benefits, burdens, and risks that might result from a given treatment, or from the withholding or withdrawal of a treatment or course of treatment.

7. My agent shall not be liable for the costs of care based solely on this authorization.

Other Provisions

I revoke any prior Appointment of Health Care Agent.

I understand that I may revoke this Appointment of Health Care Agent at any time.

This Appointment of Health Care Agent is intended to be valid in any jurisdiction in which it is presented.

Photocopies of this Appointment of Health Care Agent may be relied upon as though they were the originals.

Signature Of Declarant

By signing below, I indicate that I am emotionally and mentally competent to make this Appointment of Health Care Agent and that I understand its purposes and effect.

_____ _____
Signature of Declarant Date

_____
Print Declarant's Name

Appointment of Health Care Agent

Witness Statement

The Declarant signed or acknowledged signing this Appointment of Health Care Agent in my presence, and based upon my personal observation, the Declarant appears to be a competent individual. I am not the Health Care Agent of the Declarant. At least one of us is an individual who is not knowingly entitled to any portion of the Estate of the Declarant or knowingly entitled to any financial benefits by reason of the death of the Declarant

_____ _____
First Witness Signature Second Witness Signature

_____ _____
Print Name Print Name

_____ _____
Address Address

_____ _____
City, State, Zip Code City, State, Zip Code