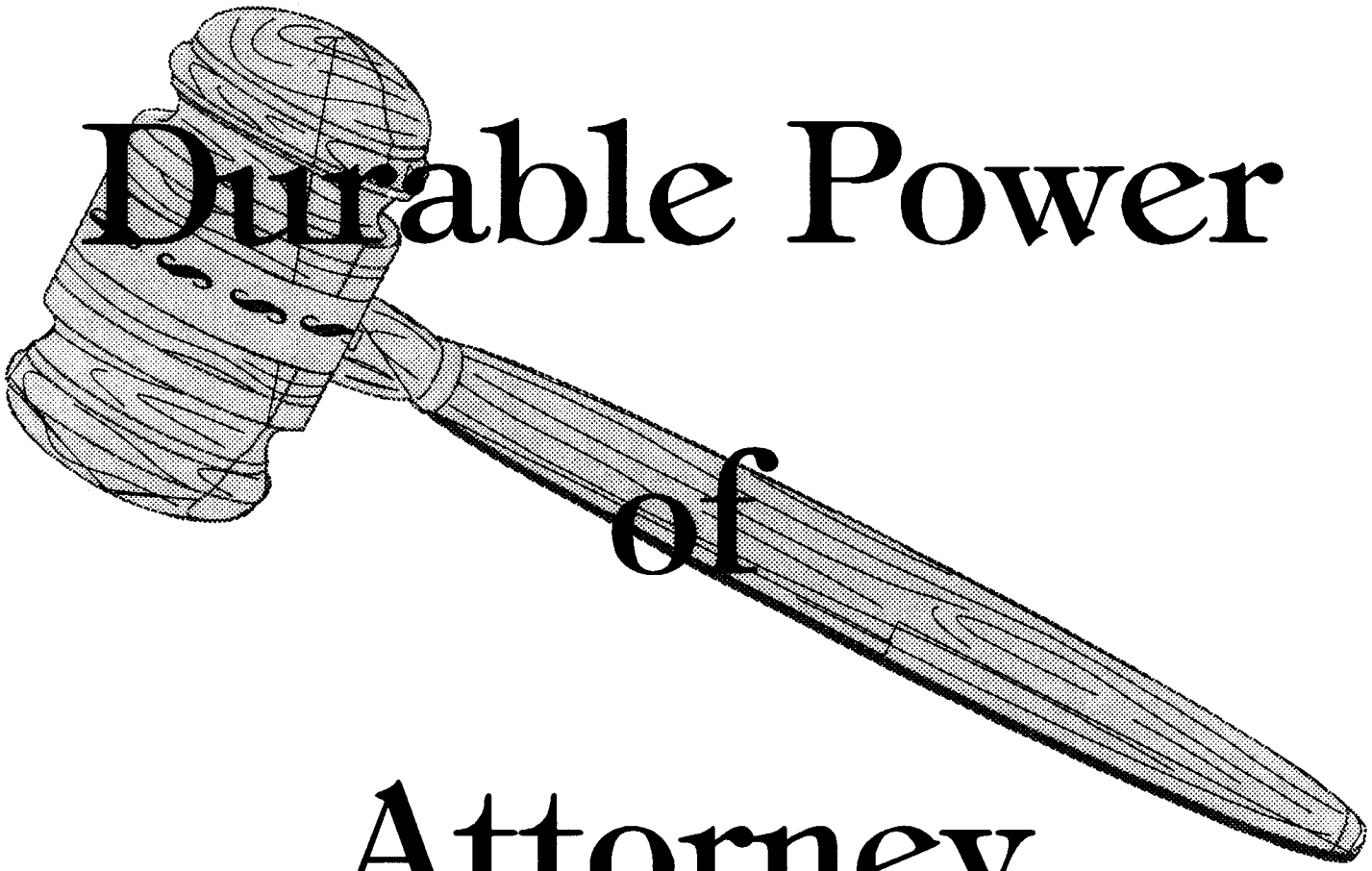
The Durable Power of Attorney

Vijay Fadia

Special State Supplement for Health Care Powers
Statutory Forms and Instructions

Completely Revised & Updated

The Durable Power of Attorney



Vijay Fadia

Special State Supplement for Health Care Powers

Statutory Forms and Instructions

IMPORTANT

Although care has been taken to ensure the accuracy and utility of the information and forms contained in this manual, neither the publisher nor the author assumes any liability in connection with any use thereof. This publication is sold with the understanding that the publisher is not engaged in rendering legal, accounting, or other professional service. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.

Published by
Homestead Publishing Company
23844 Hawthorne Blvd., Suite 200
Torrance, CA 90505
(310) 791-9975

Table of Contents

APPENDIX

Durable Power of Attorney for Health Care
State Statutory Forms

Chapter 1
Introduction to Power of Attorney

Most people are familiar with or, at least, have heard of a power of attorney. A general power of attorney is simply an instrument that authorizes a designated person to act in your behalf during a period of time. It may be specific in that the person you've appointed can carry out only certain designated transactions in the manner you have authorized. It may also be general in which case your agent has broad authority to manage your assets or execute financial transactions in your stead.

An example of such a power of attorney may be the authority you delegate to someone to sell certain stocks you own while you're away on a vacation. As a further illustration, it may be the authority you've granted an agent to sell your real estate because it's not convenient for you to participate in the transaction personally.

Drawbacks of General Power of Attorney

As you can see, a general power of attorney has its uses, and is routinely used during the principal's temporary absences. However, it has one fatal drawback. Under the common law, a power of attorney becomes inoperative upon the disability of the principal. In other words, the power is of no use just when it is needed the most — during the incapacity of the principal.

This also creates another problem, making the power less effective even when the principal is competent. Third parties dealing with the agent of the principal can never be certain that the principal has not become incapacitated and the power they are asked to rely upon has not terminated. In many instances, they may require additional assurances that the principal is still competent and the power is valid before dealing with the agent.

There is yet another consideration. Under the common law rule, the power of attorney terminates instantly upon the incapacity or death of the principal. Termination is not dependent upon the agent's or a third party's having actual knowledge of the incapacity of the principal.

Thus, all transactions taking place after the principal has become incompetent, even though undertaken in good faith, are void. Third parties, having dealt with the "former" agent of the principal, acquire no rights against the principal or his estate, nor does the principal or his estate acquire any rights against the third parties.

Civil Law vs. Common Law

It is important, at this point, to distinguish the common law rule from the civil law rule. Under the civil law rule, while the principal's death or incapacity has the effect of terminating the agent's authority, the agent's power to bind the principal, or his estate, continues until such time as the agent, or third party dealing with the agent, has actual notice of the principal's death or incapacity. The Uniform Probate Code, discussed below, adopts the civil law rule. Most states have adopted provisions of the Uniform Probate Code in enacting their Durable Power of Attorney statutes. Therefore, an agent, pursuant to the authority granted under a Durable Power of Attorney, can bind the principal as long as he does not have actual knowledge of the principal's death.

Solution — The Durable Power of Attorney

The Durable Power of Attorney is a creature of the state statutes that were designed to make a power of attorney survive the incompetency of the principal. As such, a Durable Power of Attorney is effective where a general power of attorney fails. Before we examine the solution offered by the Durable Power of Attorney, let's look at the problems created by the mental and physical disability and the traditional ways of dealing with these problems.

Chapter 2
Problems Created by Disability

As the saying goes, there're only two certainties in life: death and taxes. Many people, appreciating the inevitability of death and taxes, do provide for them by preparing a will, creating trusts, or through other estate planning means. However, the problems created by disability, physical or mental, are largely ignored. The lack of interest can be attributable to the certainty of death and the uncertainty of disability, but those who have personally experienced disability, even temporary, or have had a member of the family incapacitated know the importance of planning for such an occurrence.

Statistics on Disability

Statistically speaking, a person, at any given point in life, is more likely to suffer physical or mental disability than death. Insurance statistics tell us that a 22-year-old person is 7.5 times more likely to suffer a disability of 90 days or more than to die. At age 62, he or she is still 4.25 times more likely to suffer such a disability than to die. In fact, one out of every two Americans will suffer a lengthy period of disability during his lifetime. These figures are bound to get worse. The life expectancy of Americans, men and women, has jumped several years in the last decade, largely due to improved medical technology. Although they are living longer, an increasing number of our old people live in a state of disability. These are the realities of our modern society.

The disability may be physical or mental. A physical disability may force an individual into early retirement and impede his ability to effectively manage his assets. It may also make it impossible for him to physically supervise or participate in the management of his property. Physical disability often brings on emotional despair. Although a severely disabled person may continue to exercise sound judgment and is competent to make decisions about his financial affairs, the physical limitations may necessitate delegating power to someone else.

Mental disability presents even more serious problems for the person, for it may result in involuntary loss of capacity to make legal decisions for himself. An incompetent person cannot make a will, cannot enter into contracts, or otherwise dispose of his property.

A serious mental or physical disability can actually be more devastating than death. Death usually brings additional resources such as insurance and employee death benefits; a disability can be a severe, continous drain on the finances of the family and bring on emotional distress.

Traditional Means of Dealing with Incompetency

In the absence of any planning for the contingency, the traditional way of dealing with a person's incompetency requires petitioning a court for the appointment of a conservator, guardian or a committee. A member of the family or a close friend or a disinterested person will be required to ask the court to declare the person incompetent and appoint a conservator of the person and property.

The term "conservatorship" means some form of court-supervised administration of the assets, and perhaps of the person, of a disabled individual. Some states differentiate between the terms "conservator" and "guardian," while some others do not. The terms are often used interchangeably. A conservator of the property and person may be the same person, or there may be two different persons appointed in respective capacities. For instance, in New York, if a person is adjudged incompetent, a court may appoint a committee of the person, or of the property, or of both. However, if a person has suffered some impairment in (but not a total loss of) his ability to manage his affairs, the court may appoint a conservator, primarily to handle his property.

As part of the conservatorship proceedings, all the close relatives and other interested parties have to be given a notice of the petition. If the court approves the petition, it will appoint a conservator after scrutinizing his qualifications, particularly to ensure that he does not pose any conflict of interest with the disabled person.

Duties of a Conservator

A conservator operates in the capacity of a fiduciary. He takes control of the principal's property, prepares an inventory, posts a bond, and proceeds generally by petition and order to invest and expend principal's estate for his and his dependents' care and comfort. The conservator is required to make a periodic accounting to the court of his actions.

Disadvantages of Conservatorship Proceedings

Conservatorship or guardianship proceedings, as they are called, are highly undesirable. First, they are extremely costly. In New York state, a 1973 study revealed, the average cost of a conservatorship proceeding was

no less than $10,000 in terms of attorneys' fees and court costs. In most instances, the conservator is required to post a fiduciary's bond. Such proceedings are public and embarrassing to the person being declared incompetent and to his family. The proceedings, like any court action, are highly time-consuming.

The greatest disadvantage of conservatorship is the lack of flexibility in its administration. The powers of the conservator are severely restricted. For example, a conservator is not allowed to invade the principal of the disabled person without court approval, even though he may feel that such an expenditure would benefit the individual. He is also hamstrung when it comes to investing or expanding the capital; he may not feel secure in pursuing aggressive business or tax planning strategies. A conservatorship almost always deals a fatal blow to a business enterprise. The fact that a conservator is required to seek court approval for every major action and make periodic accountings to the court adds to the costs and delays.

Conclusion

In short, conservatorship proceedings are cumbersome, time-consuming and expensive, and should be avoided, if at all possible. A Durable Power of Attorney presents, on the other hand, an attractive and viable alternative.

Chapter 3
History of the Durable Power of Attorney

The Durable Power of Attorney is a relatively new piece of legislation. When the National Conference of Commissioners on Uniform State Laws began its work on the Uniform Probate Code in the late 1960's, it was becoming increasingly clear that an alternative had to be found to the conservatorship and guardianship proceedings for the incompetent person. Such proceedings, as we have noted in a previous chapter, are highly cumbersome, expensive and embarrassing to the family. Since a general power of attorney becomes invalid upon the incapacity of the principal, in the absence of other alternatives, guardianship or conservatorship proceedings remain the only means of providing for the incompetent person's affairs.

Uniform Probate Code

A recommended solution was to make the general power of attorney "durable" so that it will survive the incompetency of the principal. Such a result, it was proposed, can be achieved by incorporating appropriate language in the power that will indicate the intention of the maker that the authority granted shall remain unaffected during the principal's subsequent disability or incapacity or that the power shall become effective upon the disability or incapacity of the principal. The Uniform Probate Code has suggested words to the effect that "This power of attorney shall not be affected by subsequent disability or incapacity of the principal," or "This power of attorney shall become effective upon the disability or incapacity of the principal."

In 1979, the National Conference of Commissioners on Uniform State Laws patterned the Uniform Durable Power of Attorney Act, making it a freestanding statute, which can be adopted by a state as an alternative to adopting the Durable Power of Attorney provisions of the Uniform Probate Code.

At present, all fifty states have legislation on their books that authorizes writing of a Durable Power of Attorney. District of Columbia is the only exception. The actual codification of the law is included under each state supplement in this Manual and it should be carefully examined to see its applicability to your situation. Although there are some major differences, most states have either adopted in entirety or followed closely the language of the provisions of the Uniform Probate Code in their Durable Power of Attorney legislation. The Uniform Probate Code sections pertaining to the Durable Power of Attorney are reproduced below.

Uniform Probate Code

Section 5-501:

A durable power of attorney is a power of attorney by which a principal designates another his attorney-in-fact in writing and the writing contains the words 'This power of attorney shall not be affected by subsequent disability or incapacity of the principal,' or 'This power of attorney shall become effective upon the disability or incapacity of the principal,' or similar words showing the intent of the principal that the authority conferred shall be exercisable notwithstanding the principal's subsequent disability or incapacity.

Section 5-502:

All acts done by an attorney-in-fact pursuant to a durable power of attorney during any period of disability or incapacity of the principal have the same effect and inure to the benefit of and bind the principal and his successors in interest as if the principal were competent and not disabled.

Section 5-503:

(a) If, following execution of a durable power of attorney, a court of the principal's domicile appoints a conservator, guardian of the estate, or other fiduciary charged with the management of all of the principal's property or all of his property except specified exclusions, the attorney-in-fact is accountable to the fiduciary as well as to the principal. The fiduciary has the same power to revoke or amend the power of attorney that the principal would have had if he were not disabled or incapacitated.

(b) A principal may nominate, by a durable power of attorney, the conservator, guardian of his estate, or guardian of his person for consideration by the court if protective proceedings for the principal's person or estate are thereafter commenced. The court shall make its appointment in accordance with the principal's most recent nomination in a durable power of attorney except for good cause or disqualification.

Section 5-504:

(a) The death of a principal who has executed a written power of attorney, durable or otherwise, does not revoke or terminate the agency as to the attorney-in-fact or other person, who, without actual knowledge of the death of the principal, acts in good faith under the power. Any action so taken, unless otherwise invalid or unenforceable, binds successors in interest of the principal.

(b) The disability or incapacity of a principal who has previously executed a written power of attorney that is not a durable power does not revoke or terminate the agency as to the attorney-in-fact or other person, who, without actual knowledge of the disability or incapacity of the principal, acts in good faith under the power. Any action so taken, unless otherwise invalid or unenforceable, binds the principal and his successors in interest.

Section 5-505:

As to acts undertaken in good faith reliance thereon, an affidavit executed by the attorney-in-fact under a power of attorney, durable or otherwise, stating that he did not have at the time of exercise of the power actual knowledge of the termination of the power by revocation or of the principal's death, disability, or incapacity is conclusive proof of the nonrevocation or nontermination of the power at that time. If the exercise of the power of attorney requires execution and delivery of any instrument that is recordable, the affidavit when authenticated for record is likewise recordable. This section does not affect any provision in a power of attorney for its termination by expiration of time or occurrence of any event other than express revocation or a change in the principal's capacity.

Chapter 4
Glossary of Terms

Before we go any further, it's necessary to understand a few legal terms used in connection with the Durable Power of Attorney.

Principal: This is the maker of the Durable Power of Attorney. As a principal, you authorize someone to act in your stead by means of a Durable Power of Attorney. The only qualification required of a principal is that he should be capable of entering into a contract. In other words, an incompetent person cannot create a Durable Power of Attorney.

Attorney-in-fact: This is the person appointed by the principal to step into his shoes and make decisions regarding his person and property. Your attorney-in-fact may be your spouse, an adult child, a close relative or a trusted friend. Needless to say, you must exercise very good judgment in selecting the attorney-in-fact. Most states do not impose any restrictions on who can be your attorney-in-fact.

Agent: This term is synonymous with attorney-in-fact.

Conservator, Guardian: Conservator or guardian is a person appointed by court to take care of the person and property of the principal. Some states make a distinction between conservator of the property and guardian of the person, while many others do not. Same person may act in the capacity of conservator or guardian of the person and property, although sometimes two different persons may be appointed in the respective capacities.

If a person has become disabled or incapacitated, in the absence of a Durable Power of Attorney, it will be necessary to petition the court for the appointment of a conservator or guardian. Such court proceedings are referred to as conservatorship or guardianship proceedings.

Incompetent: This is the general term used to describe the physical or mental incapacity of a person. An incompetent person cannot enter into a contract. A Durable Power of Attorney can be executed only so long as you're competent. Incompetency may have been brought on by serious accident or injury, or as a result of old age and failing health.

Some states have made an attempt to define disability. Here's the way New Jersey defines it:

> A principal shall be under a disability if he is unable to manage his property and affairs effectively for reasons such as mental illness, mental deficiency, physical illness or disability, advanced age, chronic use of drugs, chronic intoxication, confinement, detention by a foreign power, or disappearance.

Indiana defines an "incompetent", "protected person", or "disabled person" as someone who is:

(1) under the age of eighteen (18) years; or
(2) incapable by reason of insanity, mental illness, mental retardation, senility, habitual drunkenness, excessive use of drugs, old age, infirmity, disappearance, or other incapacity, of either managing his property or caring for himself or both.

Life Prolonging Procedure: This is a subjective decisions which may vary from case to case. However, Virginia has codified the definition and it may be as good as any one will find.

> Life prolonging procedure means any medical procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process. "Life-prolonging procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

Chapter 5
"Springing" Durable Power of Attorney

The most common obstacle faced by planners in persuading an individual to plan for disability through the use of a Durable Power of Attorney is the general apprehension on the part of that individual that the mere creation of a power and appointment of an agent would result in his immediate loss of control over his assets. Since the individual is presently healthy and fully capable of handling his affairs, why create a power of attorney that may mean that someone else would make decisions affecting his person and property? Such fears are understandable, but proper drafting of a Durable Power of Attorney can allay such fears and contribute toward effective planning. One solution is the "springing" Durable Power of Attorney.

Statutory Language

The Uniform Probate Code authorizes the framing of a Durable Power of Attorney so that it will become effective only upon the principal's disability. In other words, the power "springs" into effectiveness when the principal has become incapacitated. Until such occurrence of incapacity, the principal continues to retain full control over his or her affairs. The power of attorney becomes a standby measure, ready to be put into effect if the disability occurs.

In order to make a Durable Power of Attorney "springing", the Uniform Probate Code suggests inclusion of the following words or similar words showing the intent of the principal that the power is to become effective only upon the disability or incapacity of the principal: "This power of attorney shall become effective upon the disability or incapacity of the principal."

Advantages of a "Springing" Power

The main advantage of a "springing" Durable Power of Attorney is to a principal, who is in perfect health at present and is capable of handling his affairs, but is reluctant to grant broad authority to someone over his person and property. A "springing" Durable Power of Attorney allows him to prepare and execute the instrument while he is competent, but defer its effectiveness until such time as it's needed. If the disability never occurs, the power is never transferred. In any event, he has provided for a future event which may force his family to undertake costly, cumbersome and embarrassing court proceedings.

Determination of Disability

The most obvious problem associated with such a power is the difficulty of determining when the power has "sprung" into effectiveness. Therefore, in drafting a "springing" Durable Power of Attorney, care must be taken to provide for a procedure for determination of the principal's incapacity — without having to go to court. The procedure should be such that third parties dealing with the agent of the principal will be satisfied that the principal has indeed become incapacitated. Anything less than the clear and convincing evidence may prompt third parties to refuse to act without a judicial declaration of incapacity, in which case all the advantage of a Durable Power of Attorney is lost.

The procedure recommended in this Manual provides for determination of the principal's incapacity when so certified in writing by two licensed physicians not related by blood or marriage to either the principal or the agent. Most third parties including banks, insurance companies, title companies will regard such a medical certification sufficiently acceptable. Of course, in some instances, they may demand evidence of continued incapacity. It may be prudent to have a certificate that is no older than six months to a year.

The other problem for the drafter of a Durable Power of Attorney is how to define incapacity. The language used in this Manual defines incapacity as when the principal has become incapable of caring for himself and when he is not physically and mentally capable of managing his financial affairs.

Some estate planners have recommended a slightly modified approach to drafting a Durable Power of Attorney. Under this approach, the power becomes effective upon either incapacity or some form of certification. In such an arrangement, the agency is established immediately but the agent is prohibited from acting until the principal (1) is determined to be incompetent, or (2) has executed a self-certification that the power has become effective.

States Authorizing "Springing" Power

The "springing" Durable Power of Attorney is not authorized in all the states. Only the states listed below have specific provisions for drafting a power of attorney that "springs" into effectiveness upon disability of the principal. There are two sets of forms provided in this Manual, one that authorizes "springing" Durable Power of Attorney and the other that does not. Depending upon your state of residence, whether it authorizes "springing" Durable Power of Attorney or not, appropriate form should be selected.

States Authorizing "Springing" Durable Power of Attorney

Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Washington, Wisconsin, Wyoming.

Immediate Power

In states that do not permit a "springing" Durable Power of Attorney, it will be necessary to execute a power that becomes effective immediately. For all practical purposes, execution of a power that becomes effective immediately should not pose any problems for you in your continued exercise of power over your assets and your ability to carry out your financial transactions — as long as you have prudently selected your attorney-in-fact and safeguarded the instrument of power to prevent possible abuse. When the need arises, the attorney-in-fact will be able to step in and exercise the authority granted.

A power that becomes effective immediately upon execution has one advantage over a "springing" Durable Power of Attorney. There's no necessity to determine if the principal has indeed become incapacitated — a determination that may require medical certification or some other procedure.

States Not Authorizing "Springing" Durable Power of Attorney

Connecticut, Florida, Georgia, Illinois, Louisiana, Mississippi, Missouri, New Hampshire, New York, Ohio, Oregon, South Carolina, Texas, Virginia, West Virginia.

District of Columbia has no Durable Power of Attorney legislation.

Chapter 6
Who Should Be Your Agent

Selection of your attorney-in-fact may be the most critical decision you'll make in creating the Durable Power of Attorney. After all, the attorney-in-fact will represent you and act in your behalf, and his actions will affect you in a very personal way, especially during times when you're incapacitated and are not in a position to make decisions for yourself. Your financial well-being and critical decisions about your health care are put in the hands of the attorney-in-fact. His or her judgment and wisdom will be of vital importance to you.

Your Attorney-in-Fact

For many people, the choice of an agent would be simple. For a married person, the most obvious choice may be the spouse. Husband and wife are intimately familiar with their financial affairs and are accustomed to making personal decisions together. However, this does not mean that the selection of the spouse to serve as agent should be automatic. A spouse may not have the experience or inclination to handle the complex financial or business affairs of the family. At the same time, the same spouse may be the perfect person to make health care and medical treatment decisions for the other spouse. In such a case, it might be appropriate to devise two separate Durable Powers of Attorney, one dealing with the health care of the principal while another dealing with the management and control of the property.

The selection of the principal's adult child as agent is another possibility that should be considered, depending upon the age, maturity, judgment of the child, and how close the principal is to the child. A friend, relative, clergyman, even a lawyer are other possible candidates as agents. As a matter of last resort, a corporate fiduciary such as a bank may be considered to serve as attorney-in-fact. Although a corporation may provide continuity, such a choice is bound to prove expensive, impersonal and, often, impractical.

Duties of the Attorney-in-Fact

An attorney-in-fact acts in the capacity of a fiduciary for the principal. His duties may be summarized as follows:

(a) The agent must act only within the scope of the authority granted in the power.

(b) At all times, he should keep the best interests of the principal in mind. He is required to act in a prudent and reasonable manner.

(c) There can be no conflict of interest between the agent and the principal.

(d) The agent is required to keep proper records, inventories and accounts of the principal's assets. He may be required to make an accounting to the principal or to a court-appointed conservator.

(e) He is not to commingle the properties and funds of the principal with either his or those of someone else.

(f) The agent must cease to act for the principal immediately upon revocation of his power or upon the death of the principal.

Successor Attorneys-in-Fact

Taking into account the possibility that an appointed agent may die, resign, or become incapacitated, a provision should be made for the appointment of a successor attorney-in-fact. This can be achieved by naming the successor agent in the Durable Power of Attorney, making the appointment contingent upon the death, resignation or disqualification of the primary agent.

Most states permit delegation of powers in the attorney-in-fact which would authorize him to select a successor attorney-in-fact. Some planners suggest designating in the power a list or class of persons from which the successor agent must be chosen.

Compensation of the Agent

Most state statutes on the Durable Power of Attorney are silent on the subject of remuneration for the attorney-in-fact.

In the absence of any specific provision for remuneration in the power, most states will apply the judicial standard of reasonableness. This may, however, produce undesirable results. At best, such a determination by a court is bound to bring uncertainty and unevenness and may create subsequent problems. It is recommended that specific provisions regarding compensation of the agent should be included in the Durable Power of Attorney itself, or in a separate agreement.

Of course, if a close family member such as the spouse or an adult child is asked to serve as attorney-in-fact, the question of compensation may not even arise. In this event, the power should state the express waiver of any fees by the agent.

Precautions

The Durable Power of Attorney grants your agent sweeping powers over your person and property. Even though the agent you have selected is someone you love and trust, prudence dictates that you take certain precautions to prevent any abuse. One way such an abuse may occur is when the agent takes actions under the Durable Power of Attorney while you're still competent and able to attend to your affairs.

It's of vital importance that you retain full control over the original and all copies of the power at all times. These should be entrusted in the hands of some other person, maybe your lawyer or other responsible party with instructions that they be not turned over to the attorney-in-fact until the need has arisen.

There's yet another area where the possibility of abuse may lie. Often, a person may choose his or her spouse to act as attorney-in-fact which is quite natural. However, occasionally the relationship sours and the marriage is dissolved. Some estate planners suggest that if a spouse is asked to act as attorney-in-fact, a clause should be included in the Durable Power of Attorney which would automatically revoke the power in the event marriage is dissolved. Of course, if the principal is still competent, he would have the option to revoke the power.

Chapter 7
Use of Durable Power of Attorney in Health Care Decisions

As we've noted before, a general power of attorney becomes invalid when the principal becomes incapacitated or incompetent. To cure this problem, all fifty states have enacted Durable Power of Attorney statutes. As a result, the use of a Durable Power of Attorney in asset management and financial transactions has become relatively commonplace. The same cannot be said about its use in authorizing health care decisions for the principal.

Health Care Powers

At present, only California and Pennsylvania have statutes that expressly permit framing of a Durable Power of Attorney for health care. The remaining states, however, do not place any restrictions on the subject matter that may be covered under a Durable Power of Attorney. The statutes, in general, authorize the appointment of an attorney-in-fact for the "care, custody and control of the person and property of the principal." Presumably, this would indicate that the agent is authorized to make decisions regarding the medical treatment of the principal.

Under a Durable Power of Attorney for health care, an attorney-in-fact would be entitled to obtain and examine all medical records and other information concerning the principal. Agent has the same right as the principal to receive information regarding the proposed health care, to receive and review medical records, and to consent to the disclosure of medical records. He would be empowered to authorize principal's admission to a medical, nursing, convalescent or similar facility, and for this purpose, he may enter into contractual agreement with the health care provider. He would also have the power to authorize medical and surgical procedures for the principal, including the administration of drugs and intravenous feeding. Under the power, he would hire and discharge doctors, nurses and other medical personnel for the benefit of the principal. Finally, in the case of a terminally ill patient, an attorney-in-fact may be called upon to make decisions regarding withholding or withdrawing of medical treatment which may include food and water.

Controversy in Health Care Decisions

This latter subject — withholding or withdrawing of life support systems including food and water from a terminally ill, comatose patient — is relatively new for the legal and medical profession as well as for the family members of the patient, and is likely to pose significant challenges in the exercise of the authority.

However, in the last few years, significant breakthrough has been made in this area as a result of certain landmark court decisions and some legislative action. It must, however, be kept in mind that the entire area of life-prolonging procedures through artificial, often heroic, measures is highly controversial and is lined with emotionally-charged advocates on either side of the issue. We are bound to see more court decisions that will shape future public policy, and also, in response, new laws that will define and clarify what can and cannot be done in such a sensitive area.

Legal Background

The common law has long recognized that a competent adult generally has the right to refuse medical treatment, even if life-sustaining, and his wishes expressed before becoming incompetent should be honored. This right is based on the common law principle of personal inviolability and self-determination. See 144 U.S. 250 (S. Ct., 1891); Cobbs v. Grant (1972), 8 Cal. 3d 229; JFK Memorial Hospital v. Heston (1971), 58 N.Y. 576, 279A. 2d 670; Erickson v. Dilgard (1962), 44 Misc. 2d 27, 252 N.Y.S. 2d 705.

In 1981, in another landmark case, the Supreme Court stated that "no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others." See Union Pacific Railway v. Botsford, 141 U.S. 250 (1981).

The principles of common law, however, are not the sole source from which the authority to control one's own destiny is derived.

Many courts have found a citizen's right of privacy implicitly guaranteed in the Bill of Rights. Although the United States Supreme Court has not ruled on the right of an individual to refuse medical treatment, it ruled, in 1973, that a woman has the constitutional right to end her pregnancy under certain circumstances. See Roe v. Wade (1973), 410 U.S. 113. In other words, the constitution guarantees every citizen broad personal right to privacy consistent with other societal values and standards.

In a more recent case, in re Matter of Eichner, an 83-year-old man was being kept alive by a respirator in a permanently vegitative state. The court was asked for permission to have the respirator removed on the ground that it was against the patient's wishes as expressed prior to his becoming incompetent. Even though such wishes were expressed only in conversations and no written instructions signed by the patient existed, the New York Court of Appeals held that a patient's right to decline treatment was guaranteed by the common law and that this right was not lost when the patient subsequently became incompetent. To put it simply, the society is expected to honor a person's wishes with regard to his right to control his destiny when expressed in unequivocal terms.

The Court of Appeals in the above case determined that it was not necessary to reach the constitutional right-of-privacy question because the relief granted to the patient was adequately supported by the common law principle of the right to autonomy. See In re Eichner, 73 App. Div. 2d 431, modified 52 N.Y. 2d 363, 420 N.E. 2d 64 (1981).

In another case, a 73-year-old fully competent man afflicted with a fatal disease requested to have a respirator removed from his trachea. The Florida District Court of Appeal upheld not only the patient's right to refuse treatment but also to affirmatively disconnect the respirator. See Satz v. Perlmutter, 362 So. 2d 160 (Fla. 1978).

Right to Delegate

The National Conference of Commissioners on Uniform Laws has proposed a Model Health Care Consent Act. It provides that individuals may exercise their right to self-determination by appointing others to act in their behalf. In other words, incompetents do not lose the right to privacy and self-determination simply due to incompetency. An alternate mechanism should be devised so that they can exercise the same right in a meaningful manner.

Sometimes, this right is expressed through a court-appointed guardian. The guardian, however, can exercise this right only after a careful judicial review. In such cases, the court applies the "substituted judgment" test where a proxy (i.e. a person acting for the incompetent person) attempts to arrive at a decision that the incompetent person would have arrived had he or she been not incompetent. The guardian's decision has to be consistent with the competing state interests and previously-expressed wishes of the incompetent person.

A good example of the "substituted judgment" test can be found in the celebrated Quinlan case. The father of the 19-year-old comatose girl was appointed her guardian and allowed to make a "substituted judgment" for the patient. Following the guardian's decision, the court permitted the respirator to be removed. See Matter of Quinlan, 355 A.2d 647 (N.J., 1976).

What if the terminally ill patient happens to be a minor child or a severely retarded person incapable of ever having made known his wishes? Can a guardian and a court apply the "substituted judgment" test in such a situation?

Apparently, the Supreme Court of Massachusetts agreed that the guardian and the court have the duty to exercise a "substituted judgment" in behalf of the incompetent person. See Superintendent of Belchertown/State School v. Saikewicz, 373 Mass. 729, 370 N.E. 2d 417 (1977). In that case, the incompetent had incurable cancer and the court found that, based on evidence, the incompetent person, if competent, would have decided not to undergo chemotherapy. By and large, the courts have held that, when a patient has no reasonable possibility of recovery and is condemned to live a vegetative existence, the patient's constitutional right to refuse medical treatment as expressed by a legal guardian outweighs any competing state interests.

A caution must be inserted at this stage lest any sweeping conclusion be reached that can be relied upon in all jurisdictions under all circumstances. Although a few states (such as California) have codified the doctrine of "substituted judgment" giving it the weight and certainty of law, it largely remains an imprecise standard used by the courts to resolve a case where the patient's wishes are unknown. The doctrine of "substituted judgment" for incompetents was specifically rejected by a New York court in another case. The state had sought to administer blood transfusions to a profoundly retarded 52-year-old man with terminal cancer. This move was opposed by the patient's mother who also was his legal guardian. The court sided with the state by permitting the blood transfusions to proceed.

As you can see, the law is in a great deal of flux, and many of today's decisions are bound to be modified, or even overturned, as the moral, ethical and legal considerations continue to sharpen society's focus on such an intensely personal subject.

Balancing with Society's Interest

In the final analysis, the right to privacy and self-determination in general, and the right to refuse medical treatment or other life-prolonging measures in particular, is not absolute. A person's right to self-determination has to be balanced with the state's basic interest in protecting and preserving human life. The state can never sanction suicide. The state also has the duty to protect other members of the society who would be affected by a person's exercise of his right to self-determination. Such a conflict may arise when a parent refuses medical treatment leaving his or her children wards of the state. The medical profession is an integral factor in this equation. The society has an obligation to preserve this integrity of the profession. An individual's desire for self-

determination has to be balanced with the medical profession's Hippocratic oath to uphold the sanctity of life. Doctors, hospitals and other health care providers are at the leading edge of the controversy and are going to be called upon to make decisions that may embroil them in legal and ethical dilemma.

Medical Profession on Trial

In a recent California case, two doctors, who had ordered removal of intravenous tubes which provided hydration and nourishment to a comatose patient, were charged with murder and conspiracy to commit murder. The patient, Clarence Herbert, had suffered a cardio-respiratory arrest during the post-operative recovery stage. He was revived by a team of physicians and nurses and immediately placed on life-support equipment. However, it was determined that the patient had suffered severe brain damage, leaving him in a vegetative state, from which he was not likely to recover.

At this point, the doctors, Robert Nejdl and Neil Barber, consulted with Mr. Herbert's family and informed them that the patient was not likely to recover from the comatose state. Thereupon, the family made a written request to the hospital personnel that they wanted "all machines taken off that are sustaining life." As a result, Mr. Herbert was taken off the respirator and other life-sustaining equipment. Mr. Herbert continued to breathe without the equipment but showed no signs of improvement.

After two more days had elapsed, the doctors, after consultation with the family, ordered removal of the intravenous tubes that had kept the patient alive. Subsequently, the District Attorney's office in Los Angeles county filed murder charges against the doctors.

The California Court of Appeals issued a peremptory writ of prohibition which, in effect, dismissed the murder complaint. In issuing the writ, the court recognized the right of a "surrogate" to act in accordance with a patient's wishes, or if none were expressed, to substitute the surrogate's judgment for that of the patient without court involvement. See Barber v. Superior Court of State of California, 147 Cal. App. 2d 1006, 195 Cal. Rep. 484 (1983).

The Barber case is a landmark authority and it will establish the viability of the Durable Power of Attorney in authorizing health care decisions for the principal, including the vesting of authority in a legal guardian or "surrogate" when the principal is incompetent and cannot make decisions for himself or herself. The court established several legal precedents:

(1) In asserting the right of an individual to self-determination, the court stated:

> In this state a clearly recognized legal right to control one's own medical treatment predated the Natural Death Act. A long line of cases, approved by the Supreme Court in Cobbs v. Grant (1972), 8 Cal. 3d 229 have held that where a doctor performs treatment in the absence of an informed consent, there is an actionable battery. The obvious corollary to this principle is that a competent adult patient has the legal right to refuse medical treatment.

The court noted that the California legislature, by enacting the Natural Death Act, has recognized an adult person's "right to control one's medical treatment."

(2) At the same time, the court concluded that California's Natural Death Act "does not represent the exclusive basis for terminating life support equipment." Obviously, such a right predates the statutory enactment. In any situation, the patient's interests and desires are of paramount importance.

> Of course the patient's interests and desires are the key ingredients of the decision-making process... whenever possible, the patient himself should be the ultimate decision-maker.

(3) Next, the court took a giant step forward by asserting the right of a "surrogate" to make health care decisions, including withholding or withdrawing of medical treatment, in behalf of the incompetent principal. The court set down specific criteria that a surrogate should follow in arriving at such decisions. First, the expressed desires and feelings of the patient prior to his becoming incompetent should be honored to the extent possible. The second criterion should be the patient's best interests which would take into account pain and suffering as well as the quality and extent of life the patient would enjoy. Finally, the surrogate ought to temper his decision by taking into account its impact on those people closest to the patient.

(4) In further strengthening the right of self-determination, the court concluded that prior judicial approval is not necessary before any decision to withdraw treatment can be made.

(5) And, as a final step, the court resolved the question of what constitutes medical treatment.

> Further, we view the use of an intravenous administration of nourishment and fluid, under the circumstances, as being the same as the use of the respirator or other form of life support.

Although the court decision did not specifically mention the use of a Durable Power of Attorney to authorize health care and medical treatment decisions, it recognized the right of an individual to express his wishes through either written or oral communication. In its decision, the court cited several times the Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment, U.S. Government Printing Office, Washington D.C. (1983). The Report recom-

mended the use of the Durable Power of Attorney as a effective mechanism for the purpose of allowing people while competent to designate someone to act in their stead and to express their wishes about treatment.

Withholding of Food and Water

Although the Barber case discussed above made no distinction between the intravenous administration of nourishment and fluid and the use of the respirator or other form of life support, putting them both in the category of medical treatment, the propriety of withdrawing nourishment and hydration from a terminally ill, comatose patient continues to present the most problematical issue for the courts. Presently there is another case making its way up in the Massachusetts judicial system which is expected to set new medical and legal boundaries in the area of feeding of the comatose patients.

For almost three years, Paul Brophy, 48, a former firefighter and paramedic, has lain in a coma at a chronic care hospital in Stoughton, Mass., kept alive against his previously-stated wishes, by feeding through a tube surgically placed in his stomach. He has no awareness of his surroundings and does not move, except reflexively to withdraw from being touched. Brophy had been in excellent health until three years ago, when a blood vessel ruptured in his brain. He never regained consciousness after delicate neurosurgery.

Ironically, long before he became ill, Brophy had spoken to his wife about his desire not to be kept alive in a coma, partly because he had seen so many seriously injured accident victims in the course of his job. Although Brophy never specifically discussed with any member of his family the issue of whether food and water should be withdrawn, he had repeatedly told his wife to "pull the plug" if he should ever end up in a coma.

A state probate judge has agreed with Brophy's wife and legal guardian, Patricia, that her husband, if he were able to see his current condition, would forgo such feeding in order to terminate his life. Yet the judge ruled in Oct. 1985 that the feedings were neither "burdensome" nor "painful" and must be continued. This decision is being appealed.

Right-to-Die

At the time this material is being written (April, 1986), the outer perimeters of the right to self-determination, particularly the right to refuse food and water, are still not defined. In addition to the Brophy case, there are similar cases pending in New Jersey, Florida and California. The outcome of these cases will have broad implications on the nation's estimated 10,000 comatose individuals who are being kept alive in persistent vegetative states.

The legal battle over whether food and water can be withheld from a comatose patient has become the latest confrontation between "right-to-life" and "right-to-die" advocacy groups. In the past, like the Karen Ann Quinlan case in New Jersey a decade ago, the controversy raged around the issue of disconnecting life-support equipment from comatose patients. But now the focus has shifted toward withdrawing nourishment and hydration from patients who are in a totally vegetative state. Some physicians, members of the clergy and other "right-to-life" advocates do not consider food and water as medical treatment at all but as nursing care akin to keeping a patient warm or turning a patient in bed. However, most courts, including the California court in the Barber case mentioned above, have ruled that nourishment and hydration are no different than other traditional forms of medical treatment.

The central issue that the courts are grappling with is whether a patient, who is in a persistent coma with no possible hope of recovery but with a life expectancy of several more years, has a right to starve himself to death. Ironically, the California courts have again taken a lead in further expanding the right of an individual to control his or her destiny, including the right to die.

The California case involves a 28-year-old cerebral palsy victim, totally paralyzed and dependent on others for continuous care. Originally the patient, Elizabeth Bouvia, had sought court's permission to starve herself to death while being cared for in a county-run hospital. The woman's illness, while incurable, is not terminal. With proper care, she is expected to live 15 to 20 years. Although she suffers from a severely debilitating physical ailment, she is by no means incompetent. In fact, she has full control over her mental faculties, and is capable of making decisions for herself.

The trial court rejected her request to starve herself, declaring that her right to privacy and self-determination was outweighed by society's interest in preserving life and maintaining ethical integrity of the medical profession. The judge noted, "She has a right to end her life, but not with the assistance of society." Bouvia v. County of Riverside (1983), Riverside Superior Court No. 159780.

Currently, a second chapter is being written in this story. Bouvia, no longer wanting to starve herself to death, petitioned the court to have doctors remove the force-feeding tube that carries vital nutrients to her body. The force-feeding was initiated because her weight had dropped dangerously. The request was denied by the trial judge who ruled that, under the circumstances of her present hospitalization, Bouvia does not have an absolute right to refuse medical treatment. Bouvia, represented by ACLU, appealed the decision.

The state appellate court recently ruled that Elizabeth Bouvia has an absolute right to refuse force-feeding or any other unwanted medical treatment, even if it creates a life-threatening situation. In a powerfully worded,

unanimous decision, the 2nd District Court of Appeal ordered removal of a nasogastric tube through which the 28-year-old woman was receiving the vital nutrients.

"A patient has the right to refuse any medical treatment or medical service, even when such treatment is labeled 'furnishing nourishment and hydration,'" the justices held. Such a right is "basic and fundamental" and is "recognized as part of the right of privacy protected by both the state and federal constitutions."

"It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. It is not a conditional right subject to approval by ethics committees or courts of law. It is a moral and philosophical decision that, being a competent adult, is hers alone."

The Appellate court found that it is "immaterial that the removal of the ... tube will hasten or cause Bouvia's eventual death. Being competent, she has the right to live out the remainder of her natural life in dignity and peace."

This right, the court wrote, "should include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible."

American Medical Association Guidelines

Finally, just as we go to press with this Manual, important guidelines are being written by the medical profession. During a two-day symposium in March, 1986 in New Orleans titled, "A New Ethic for the New Medicine," the American Medical Association announced a major change in the principles regarding the treatment of terminally ill and permanently incapacitated patients, maintaining that a doctor remains obligated to sustain life, not prolong it. Under these guidelines, it would be ethical for a doctor to withhold "all means of life prolonging medical treatment," including food and water, from patients in irreversible comas even if death was not imminent. The withholding of such therapy should occur only when a patient's coma "is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis," the association's judicial council said.

The opinion could affect at least 10,000 Americans who are in irreversible comas.The opinion of the 271,000-member association does not constitute a hard and fast rule for doctors, but it opens the way for them to withdraw life-prolonging treatment with less fear of being taken to court, and to cite the opinion as a defense if they are challenged.

The association emphasized that the new ruling "does not say that a physician has to pull out IV's or a feeding tube. The ruling states that doing so "is not unethical" and is a decision that each physician and each patient's family and legal guardians would address on a case-by-case basis. Even with the new ruling, it is expected, many doctors will choose to believe that withholding food and water would cause intentional death.

The new AMA opinion also said: "Life prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained."

Chapter 8
Living Will

Since 1976 many states have enacted "living will" laws. These laws — sometimes called "right-to-die" or "death-with-dignity" statutes — generally establish a person's right to sign a legally effective declaration that says that, should he become terminally ill, he wants no extraordinary measures used to prolong life. At this time, 35 states and the District of Columbia have recognized a terminally ill patient's right to say 'no' to further treatment. Living will laws free doctors and other health care providers from liability when they act in accordance with the patient's instructions.

At present, the laws vary in detail from state to state. A number of states require a diagnosis of "terminal illness" not only from the attending physician but also from a second doctor. Almost all insist on two witnesses to the signing of the living will, but several states specify that the process take place before a notary public. Some allow the person to designate a close relative or other proxy to make crucial medical care decisions should he be incompetent to make them himself; others rule out decisions by anyone but the patient. Most laws on the book specify that withdrawal of life-sustaining procedures pursuant to a living will does not sanction withdrawal of food and water.

It's recommended that you review your living will declaration periodically and re-execute it to keep it current. If a terminal illness has been diagnosed recently, a new declaration should be executed. A commonly-used living will form is included in this Manual; it should be signed in the presence of three witnesses. Such a will may be legally binding and enforceable even in states that do not have living will laws on the book, but this is not as clear and as certain as in those states that have specific laws on the subject.

When States Passed "Living Will" Laws

1976	California
1977	Arkansas, Idaho, Nevada, New Mexico, North Carolina, Oregon, Texas
1979	Kansas, Washington
1981	Alabama
1982	Delaware, District of Columbia, Vermont
1983	Illinois, Virginia
1984	Florida, Georgia, Louisiana, Mississippi, West Virginia, Wisconsin, Wyoming
1985	Arizona, Colorado, Connecticut, Indiana, Iowa, Maine, Maryland, Missouri, Montana, New Hampshire, Oklahoma, Tennessee, Utah

Living Will

To my family, my physician, my lawyer, and my clergyman:

To any medical facility in whose care I happen to be:

To any individual who may become responsible for my health, welfare, or affairs:

I,_____ wish to make this statement as an expression of my desires and directions while I am still of sound and competent mind. If a time comes when I can no longer take part in decisions regarding my own well-being, let this statement serve as a guide to all those who care for me.

Should a situation arise when there is no reasonable expectation of my recovering from extreme physical or mental disability, I request that I be allowed to die and not be kept alive by artificial means or "heroic measures" undertaken by medical personnel. I do, however, ask that medication be mercifully administered to me to alleviate pain and suffering even though this may hasten the moment of death.

If I have executed a valid form of bequeathal of any of my organs for transplant or research purposes, I do ask and authorize that I be kept alive by artificial means for a time sufficient to enable the medical personnel to accomplish the withdrawal of the organs.

I am making this request after careful consideration and is in accordance with my beliefs and convictions. I hope that those who care for me will feel morally bound to carry out my wishes as expressed here.

Date: _____ Signature: _____

_____
Witness

_____
Witness

_____
Witness

Chapter 9
Alternatives to the Durable Power of Attorney

The Durable Power of Attorney is a relatively new concept. The legislation dealing with the Durable Power of Attorney has been adopted in most states only in the last dozen years or so. Previous to such legislation, the problem of handling an incapacitated person's financial and personal affairs was generally handled through legal guardianship or conservatorship proceedings. Such proceedings have always been cumbersome, inflexible and expensive. A Durable Power of Attorney can provide a solution to these problems. Besides the Durable Power of Attorney, there is one other approach that deals with the problems of disability.

Revocable Living Trust

A revocable Living Trust is a device whereby you transfer your assets to a trust during your lifetime; you can appoint yourself as settlor or trustee and designate in the trust instrument beneficiaries of the trust. The primary purpose of a Living Trust is to avoid probate by facilitating an immediate transfer of the trust assets to the beneficiaries upon death.

However, the same arrangement is frequently used to handle problems arising out of the settlor's subsequent incompetency during his lifetime. The declaration of trust may contain a provision which empowers successor trustee to take over the administration of the trust during the lifetime of the settlor, should he become physically or mentally incapacitated. Such incapacity is established upon certification by at least two licensed physicians not related by blood or marriage to either the settlor or any beneficiary. The successor trustee could be the spouse, an adult child, a relative or a friend of the settlor, and in some instances, a bank or a financial institution. The successor trustee is directed to spend as much of income and principal as may be necessary for the proper health, support and maintenance of the settlor.

Although a Living Trust is an excellent device to avoid probate, its use in handling problems created by a person's disability is not quite as desirable as using a Durable Power of Attorney. The following is a brief discussion of the relative merits of the two approaches:

1. First, setting up a Living Trust and implementing the trust by transferring various assets to the trust is an expensive proposition, especially if the sole purpose of the Living Trust is to provide against incompetency and that incompetency never occurs. A Living Trust requires that the assets named in the trust be transferred to the trust by re-recording the deeds for real estate, or changing the bank accounts or insurance policies. This is a time-consuming procedure. The cost and time spent are well-justified if the primary objective is to avoid probate and provision against incompetency is a secondary goal.
2. A Durable Power of Attorney can provide for personal health care of the principal, but a Living Trust cannot. Therefore, even if a Living Trust is used for financial and asset management, a Durable Power of Attorney may still be needed for personal health care decisions.
3. In almost all the states, a Durable Power of Attorney can be executed without any court approval and without the formality of public recording. It is a much more informal arrangement and, often, the entire matter can be handled with the help of a few family members.
4. Most states do not limit the powers that may be granted the attorney-in-fact in a Durable Power of Attorney. These can be as broad or restrictive as you wish. Also, in many states, you can frame the power so as to be effective only upon the disability of the principal, the so-called "springing" Durable Power of Attorney. Thus, the Durable Power of Attorney can be held in abeyance until the need arises.
5. As opposed to a Living Trust, a Durable Power of Attorney does not require even a nominal transfer of assets. It's a boon to those who are fearful of losing even the slightest control over their affairs.

Convertible Inter Vivos Trust

Fortunately, it's not necessary to choose between the Durable Power of Attorney and the revocable Living Trust. The Durable Power of Attorney and the revocable Living Trust can not only exist concurrently, they can, in fact, complement one another. The use of a convertible inter vivos trust (i.e. a Living Trust set up in conjunction with a Durable Power of Attorney) can offer the best of both worlds; it becomes the most comprehensive, cost-efficient and flexible estate planning device.

The revocable Living Trust set up under such an arrangement would be unfunded, or preferably, funded with a minimal amount of property. (Some states do not permit unfunded or "dry" or "passive" Living Trusts. To cir-

cumvent such rules, it's recommended that the trust be set up with a small amount of property.) The declaration of trust grants the trustee the right to receive additional property from any source, including "pour-overs" from the grantor's estate.

In conjunction with the Living Trust, a Durable Power of Attorney is also drafted which expressly directs the attorney-in-fact, upon disability of the principal, to transfer and deliver to the trustee all of the principal's property. It may be desirable to identify the specific assets or the classes of assets to be transferred to the trust, including a catch-all provision that would cover all the property owned by the grantor. Both the instruments of power and trust may define "disability" as certified by two unrelated licensed physicians or in some such non-judicial manner. Upon disability of the grantor, the previously revocable trust "converts" to an irrevocable trust for the benefit of the grantor and other designated beneficiaries. At the time of conversion, the grantor is automatically disqualified as trustee and is then replaced by a successor trustee named in the instrument. Also, at this time, the grantor relinquishes all right and power, previously reserved unto him, to revoke or amend the trust. Such a provision should be included for two-fold reasons. First, an attempt by an incapacitated or incompetent person to amend or revoke a trust is likely to be challenged successfully by affected beneficiaries in a court of law. Second, by making the trust irrevocable upon disability of the principal, if a conservator were to be appointed by court, he would be prevented from revoking or otherwise negating the terms of the trust originally intended by the principal.

In many states, a principal has the right to nominate his choice of conservator in the Durable Power of Attorney, and the court is required to appoint such a conservator unless there is good cause or the conservator is disqualified. This would leave the judicial intervention to the minimum.

The principal benefit of a convertible Living Trust described above is that it puts off into the future the expensive and time-consuming process of funding a Living Trust. The device of executing a Living Trust together with a Durable Power of Attorney permits the "standby" Living Trust to be funded only if and when incompetency actually occurs.

Such a device has the additional benefit of affording the principal psychological comfort in that the power of attorney-in-fact is fairly limited — he is required only to transfer the assets owned by the principal to the existing Living Trust upon determination of disability. The principal may feel more comfortable in granting such limited authority and an attorney-in-fact may be more willing to accept such a responsibility.

An exhaustive discussion of revocable Living Trust is beyond the scope of this Manual. Those who are interested in setting up a revocable Living Trust for the primary purpose of avoiding probate should write to the publisher of this Manual inquiring about **How to Avoid Probate Kit.**

If you wish to grant your attorney-in-fact authority to fund an existing inter-vivos trust, the following clause may be added to the Durable Power of Attorney.

> I have created an inter vivos Trust dated _____. In the event of my "disability" as that term is defined in the said Declaration of Trust, I hereby direct my attorney-in-fact to transfer and deliver any deed or other instrument of transfer or conveyance covering all of my personal and real property wherever situated to the Trustees of said Trust for administration and management pursuant to the terms of said Declaration.

Chapter 10
Tax Consequences

A Durable Power of Attorney, per se, does not pose any serious tax consequences for either the principal or the agent. However, an agent can take certain actions that may benefit the principal. This may entail completing specified gifts, or buying bonds to pay estate taxes, or buying more insurance for the principal, or funding a revocable Living Trust. A brief discussion of a few related issues ensues below.

Principal Taxed

A Durable Power of Attorney simply authorizes an attorney-in-fact to act in behalf of the principal without transferring any benefits of ownership of property or undertaking. An agent may have a legal title to a property but no beneficial interest in it. Therefore, all of the income, gift and estate tax consequences arising out of any Durable Power of Attorney transactions are borne by the principal. For example, if an agent sells the principal's property and gain is realized, the gain is, of course, taxed to the principal.

If any agent makes a gift of the principal's property to someone else, the action results in a taxable gift transaction for the principal.

Flower Bonds

Section 6312 of the Internal Revenue Code permits certain federal bonds, issued on or before March 3, 1971, to be used at their par value in payment of the federal estate tax. These are so-called "flower bonds." Such bonds provide an instant source of cash for the estate.

The flower bonds must have been purchased by the decedent during his lifetime or by an authorized person, such as a trustee or agent acting in behalf of the principal. The regulations of the Treasury Department require the bonds to have been owned by the decedent at the time of his death and thus, are included in the taxable estate of the decedent at par value.

If you wish, you may specifically authorize your agent in the Durable Power of Attorney to purchase flower bonds so that they can be redeemed upon death to pay federal estate tax.

It should be noted that the flower bonds are gradually being phased out. The Treasury Department has not issued any since 1971. Flower bonds generally bear a lower rate of interest than other government securities. They are not a good investment except when purchased shortly before the death of the owner.

Life Insurance

Life insurance, especially the issue of "incidents of ownership," may pose a difficult problem for the estate planner. Under Treasury regulations, life insurance is included in the decedent's estate if he owns any incidents of ownership.

Take, for instance, an arrangement described below which may not be entirely uncommon. Husband assigns insurance policy on his life to his wife, and then separately, she appoints him as her attorney-in-fact under a Durable Power of Attorney. If the husband predeceases his wife, is the policy included in his gross estate since he owned "incidents of ownership?"

There is no definitive ruling on this question. The IRS has, however, conceded in at least one case that the "powers possessed by the decedent in a fiduciary capacity do not constitute incidents of ownership for the purposes of Section 2042(a) where they devolve on the decedent after the decedent has divested himself or herself of all interest in the policies and where the decedent cannot exercise the powers for the decedent's own benefit."

Durable Power of Attorney or Living Will?

Durable Powers of Attorney for health care have important advantages over living wills. Living wills are primarily used when a patient is terminally ill and death is imminent, whereas a durable power of attorney for health care can generally be used to delegate authority for health care decisions in all cases of patient incompetence. In other words, durable power of attorney has much wider application than living will.

Durable power of attorney, unlike a living will, offers a crucial benefit to the attending physician in that he can talk to the agent who is authorized to make decisions in behalf of the patient. Physicians will feel less vulnerable to legal challenges if they rely upon the instructions of the agent who was personally designated by the incompetent patient, than if they were to rely upon the informal consent of a relative. The durable power of attorney for health care resolves uncertainty about who is authorized to consent for the incapacitated patient, especially when relatives are in disagreement among themselves or when the family disagrees with the physician. The concept of durable power of attorney conforms more closely than a living will to the legal model of informed consent.

The obvious disadvantage of durable power of attorney is possible abuse by the agent, if he stands to gain by unscrupulous exercise of the power vested in him by the principal. Such a possibility can, of course, be averted by judicious selection of the agent. Second concern in the exercise of durable power of attorney is that the agent may not exercise the very power when needed that he is authorized and trusted to exercise. A close family member who acts as the agent may be too overwhelmed by grief or too emotionally overwrought to make the critical decision. So there exists the ever-present danger of an agent not faithfully carrying out the patient's wishes or acting against the patient's best interests when those wishes are unclear.

There is one other significant difference between living wills and durable powers of attorney for health care. Agents under a durable power of attorney for health care are not required to act for the principal; they are given the power, but not the obligation. On the other hand, living will directives are obligatory on the physician. Powers granted an agent to act on behalf of the principal are permissive.

Chapter 11
Form Selection and Instructions

Instructions — Read Carefully

Form Selection

1. Find the state of your residence in Column 1.
2. Column 2 shows different forms you can use. You may create two separate powers — one for asset management, the other for health care, or you may create one combined power for asset management and health care. You may create an immediate power or, if your state permits it, a "springing" power.

Although most states make no express provision for health care in their Durable Power of Attorney statutes, estate planners generally agree that a power that provides for health care decisions may nonetheless be valid.

Residents of California, Connecticut, New York and North Carolina can also choose to use statutory short form power of attorney. These forms were written by the legislature and allow you to adopt comprehensive powers by reference. They are simple to use and are bound to find wide acceptance among third parties with whom your agent will be dealing. You should use these forms, if at all possible. If you decide not to use a statutory form, which you're not required to do, you may select one of the other standard forms.

California is the only state that has adopted a statutory form for health care. California residents cannot combine health care powers with asset management powers. Residents of other states can use Form DPA-3 or DPA-4 to create a separate Durable Power of Attorney for health care.

Executing the Standard Form

Once you have selected a form or forms, follow the instructions below for completing the forms:

1. Type your name and address as principal in the space provided.
2. Type the name and address of your agent in the space provided.
3. Type the name and address of a successor/substitute agent where shown. If you decide not to appoint a successor/substitute agent, type "NONE."
4. Since most powers may involve dealing with real property and may need to be recorded, you should execute the power in the presence of a Notary Public. Type the city/town and state, and the date of preparing the power. Type your name and sign above it.
5. Notarial acknowledgment must be completed by the Notary Public.
6. Although most states do not require witnesses, it's recommended that you sign the document in the presence of two witnesses. The witnesses must sign in the spaces provided.

Caution: South Carolina requires that the power must be executed with the same formality as involved in the execution of a will and recorded in the same manner as a deed.

7. At the end of the instrument, the agent may sign acknowledging his/her appointment by the principal. This, of course, is not a requirement.

Statutory Short Form Power of Attorney

The statutory forms include specific warnings and instructions for execution of the power. You should read these carefully and follow them.

Health Care Power

Caution: The Durable Power of Attorney for health care has two provisions that you should pay special attention to. First, in the event of a terminal illness, it expressly asks the health care provider to withhold or withdraw any life-prolonging procedures. Second, in the event of an irreversible coma, it asks for suspensions of nourishment and water.

If you do not agree with either one or both of these provisions, you must cross out the applicable paragraphs and initial them. If you're using witnesses, you must have them initial the alterations too.

If you're a resident of	Select	Comment
Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Dakota, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Washington, Wisconsin	Form DPA-1	DPA for Asset Management; Immediate Power.
	Form DPA-2	DPA for Asset Management; "Springing" Power.
	Form DPA-3	DPA for Health Care; Immediate Power.
	Form DPA-4	DPA for Health Care; "Springing" Power.
	Form DPA-5	DPA for Asset Management and Health Care Combined; Immediate Power.
	Form DPA-6	DPA for Asset Management and Health Care Combined; "Springing" Power.
Florida, Georgia, Illinois, Louisiana, Mississippi, Missouri, New Hampshire, Ohio, Oregon, South Carolina, Texas, Virginia, West Virginia	Form DPA-1	DPA for Asset Management; Immediate Power.
	Form DPA-3	DPA for Health Care; Immediate Power.
	Form DPA-5	DPA for Asset Management and Health Care Combined; Immediate Power
California	Form DPA-7	California Statutory Short Form Power of Attorney; Recommended.
	Form DPA-8	California Statutory Form Durable Power of Attorney for Health Care; Recommended.

	Form DPA-9	DPA for Asset Management; Immediate Power; Contains the Required California Warning.
	Form DPA-10	DPA for Asset Management; "Springing" Power; Contains the Required California Warning.
	Form DPA-11	DPA for Health Care; Immediate Power; Contains the Required California Warning.
	Form DPA-12	DPA for Health Care; "Springing" Power; Contains the Required California Warning.
Connecticut	Form DPA-13	Connecticut Statutory Short Form Power of Attorney; Recommended.
	Form DPA-1	DPA for Asset Management; Immediate Power.
	Form DPA-3	DPA for Health Care; Immediate Power.
	Form DPA-5	DPA for Asset Management and Health Care Combined; Immediate Power.
New York	Form DPA-14	New York Statutory Short Form of General Power of Attorney; Recommended.
	Form DPA-1	DPA for Asset Management; Immediate Power.
	Form DPA-3	DPA for Health Care; Immediate Power.

	Form DPA-5	DPA for Asset Management and Health Care Combined; Immediate Power.
North Carolina	Form DPA-15	North Carolina Statutory Short Form of General Power of Attorney; Immediate Power; Recommended.
	Form DPA-16	North Carolina Statutory Short Form of General Power of Attorney; "Springing" Power; Recommended.
	Form DPA-1	DPA for Asset Management; Immediate Power.
	Form DPA-2	DPA for Asset Management; "Springing" Power.
	Form DPA-3	DPA for Health Care; Immediate Power.
	Form DPA-4	DPA for Health Care; "Springing" Power.
	Form DPA-5	DPA for Asset Management and Health Care Combined; Immediate Power.
	Form DPA-6	DPA for Asset Management and Health Care Combined; "Springing" Power.
Oklahoma, Wyoming	Requires Court Approval	You may use the language of the Forms DPA-1, DPA-2, DPA-3, DPA-4, DPA-5, or DPA-6. But the power requires court approval and there are restrictions. Please read the State Supplements.

DURABLE POWER OF ATTORNEY
(Immediate Power)

Created by _____ as Principal.

1. I, _____
Name of Principal

of _____, _____, _____
Address *City* *State*

as principal (the "Principal") intend to create by this instrument a Durable Power of Attorney and do hereby appoint

_____ of
Name of Agent

_____
Address *City* *State*

("Agent") to act for me and in my name and exercise the powers set forth below.

2. My Agent is authorized in my Agent's sole and absolute discretion from time to time and at any time, with respect to any and all of my property and interests in property, real, personal, intangible and mixed, as follows:

(a) Real Property Transactions: To lease, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any interest in real property whatsoever, on such terms and conditions, and under such covenants, as my Agent shall deem proper; and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens, mortgage, subject to deeds of trust, and in any way or manner deal with all or any part of any interest in real property whatsoever, that I own at the time of execution or may thereafter acquire, for under such terms and conditions, and under such covenants, as my Agent shall deem proper; and, to supplement this instrument by adding or modifying the descriptions of any property, real or personal, which I may now or hereafter own, in whole or in part.

(b) Personal Property Transactions: To lease, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any personal property whatsoever, tangible or intangible, or interest thereto, on such terms and conditions, and under such covenants, as my Agent shall deem proper, and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens, mortgages, subject to deeds of trust, and hypothecate, and in any way or manner deal with all or any part of any real or personal property whatsoever, tangible or intangible, or any interest therein, that I own at the time or execution or may thereafter acquire, under such terms and conditions, and under such covenants, as my Agent shall deem proper.

(c) Bond, Share and Commodity Transactions: To request, ask, demand, sue for, recover, collect, receive, and hold and possess any bond, share, instrument or similar character, commodity interest or any instrument with respect thereto together with the interest, dividends, proceeds, or other distributions connected therewith, as now are, or shall hereafter become, owned by, or due, owing payable, or belonging to, me at the time of execution or in which I may thereafter acquire interest; to have, use, and take all lawful means and equitable and legal remedies, procedures, and writs in my name for the collection and recovery thereof, and to adjust, sell, compromise, and agree for the same, and to make, execute, and deliver for me, all endorsements, acquittances, releases, receipts, or other sufficient discharges for the same.

(d) Banking Transactions: To make, receive, sign, endorse, execute, acknowledge, deliver, and possess checks, drafts, bills of exchange, letters of credit, notes, stock certificates, withdrawal receipts and deposit instruments relating to accounts or deposits in, or certificates of deposit of, banks, savings and loan or other institutions or associations for me.

(e) Safe Deposits: To have free access at any time to any safe deposit box or vault to which I might have access; and to contract with any institution for the maintenance of a safe deposit box in my name; and to add to and remove from the contents of any such safe deposit box.

(f) Business Operating Transactions: To conduct, engage in, and transact any and all lawful business of whatever nature or kind for me; to continue the operation of any business I own or have an interest in; to sell, liquidate or close out such business at such time and upon such terms as my Agent shall deem appropriate; to represent me and to exercise any right or power I may have in any partnership whether as a general, special or limited partner; to exercise all rights with respect to any securities I may now own or acquire hereafter in any public corporation, including the right to sell, hypothecate, buy the same or different securities and to vote at all meetings of the stockholders.

(g) Insurance Transactions: To exercise or perform any act, power, duty, right or obligation whatsoever in regard to any contract of life, accident, health, disability or liability insurance of any combination of such insurance procured by or on behalf of me prior to execution; and to procure new, different or additional contracts of insurance for me and to designate the beneficiary of any such contract of insurance, provided, however, that the Agent himself cannot be such beneficiary unless the Agent is my spouse, child, grandchild, parent, brother or sister.

(h) Estate Transactions: To request, ask, demand, sue for, recover, collect, receive, and hold and possess all legacies, bequests, devises, as are, owned by, or due, owing, payable, or belonging to, me at the time of execution or in which I may thereafter acquire interest; to have, use, and take all lawful means and equitable and legal remedies, procedures, and writs in my name for the collection and recovery thereof; and to adjust, sell, compromise, and agree for the same, and to make, execute, and deliver for me, all endorsements, acquittances, releases, receipts, or other sufficient discharges for the same.

(i) Personal Relationships and Affairs: To do all acts necessary for maintaining the customary standard of living for me, my spouse and children, and other dependents; to provide medical, dental and surgical care, hospitalization and custodial care for me, my spouse, and children and other dependents; to continue whatever provision has been made by me, for me, my spouse, and children, and other dependents, with respect to automobiles, or other means of transportation; to continue whatever charge accounts have been operated by me, to open such new accounts as my Agent shall think to be desirable for the accomplishment of any of the purposes enumerated in this section, and to pay the items charged on such accounts by any person authorized or permitted by me or my Agent to make such charges; to continue the discharge of any services or duties assumed by me, to any parent, relative or friend of mine; to continue payments incidental to my membership or affiliation in any church, club, society, order or other organization, or to continue contributions thereto.

(j) Tax, Social Security and Unemployment: To prepare, execute and file all tax, social security, unemployment insurance and information returns for tax years between 1970 and 2020 required by the laws of the United States, or of any state or subdivision thereof, or of any foreign government; to prepare, execute and file all other papers and instruments which the Agent shall think to be desirable or necessary to safeguard me against excess or illegal taxation or against penalties imposed for claimed violation of any law or other governmental regulation; and to pay, compromise, contest or apply for refunds in connection with any taxes or assessments for which I am or may be liable.

(k) Benefits from Military Service: To execute vouchers in my name for any and all allowances and reimbursements payable by the United States, or subdivision thereof, to me, arising from or based upon military service and to receive, endorse and collect the proceeds of any check payable to me drawn on the treasurer or other fiscal officer or depository of the United States or subdivision thereof; to take possession and to order the removal and shipment, of any property belonging to me from any post, warehouse, depot, dock or other place of storage or safekeeping, either governmental or private; to execute and to deliver any release, voucher, receipt, bill of lading, shipping ticket, certificate or other instrument which the Agent shall think to be desirable or necessary for such purpose; to prepare, to file and to prosecute my claim to any benefit or assistance, financial or otherwise, to which I am or claim to be, entitled, under the provisions of any statute or regulation existing at the creation of the agency or thereafter enacted by the United States or by any state or by any subdivision thereof, or by any foreign government, which benefit or assistance arises from or is based upon military service performed prior to or after execution.

(l) Revocable Trust: To execute a revocable trust agreement with such trustee as my Agent shall select which trust shall pay to me or disburse on my behalf such amounts of income or principal as necessary for my proper health, support and maintenance, and that on my death any remaining income and principal shall be paid to my personal representative, and that said trust may be revoked or amended by me or my Agent at any time and from time to time, provided that any such amendment by my Agent shall not include any provision which could not be included in the original trust agreement; to deliver and convey any or all of my assets to the trustee thereof; to add any or all of my assets to such a trust already in existence at the time this instrument is executed or at any time thereafter.

3. This power of attorney shall not be affected by subsequent disability or incapacity of the principal.

4. No person who acts in reliance upon any representations made by my Agent as to (a) the continued validity of the Durable Power of Attorney, (b) the scope of powers granted under this instrument, (c) my competency at the time this instrument was executed, or (d) the fact that this instrument has not been revoked, shall incur any liability to me, my estate, my heirs or assigns as a result of any dealings with my Agent, nor shall any person who deals with my Agent shall inquire into the proper application of funds or property.

5. I reserve unto myself the right to amend or revoke this instrument, and to remove my Agent and any alternate agent by executing a written instrument of revocation, amendment, or removal and delivering it to my Agent and to all alternate agents. If the instrument has been recorded in the public records, then the instrument of revocation, amendment or removal shall be filed or recorded in the same public records.

6. If my spouse has been appointed as my Agent herein, and subsequent to the execution of this instrument, legal proceedings are instituted for separation and dissolution of our marriage, institution of such proceedings shall automatically remove my spouse as my Agent.

7. My Agent shall be entitled to reimbursement for all reasonable costs actually incurred and paid by my Agent on my behalf under the authority granted in this instrument.

8. To the extent permitted by law, I herewith nominate, constitute and appoint my Agent to serve as my guardian, conservator and/or in any similar representative capacity; and, if I am not permitted by law to so nominate, constitute and appoint, then I request any court of competent jurisdiction which may be petitioned by any person to appoint a guardian, conservator or similar representative for me to give due consideration to my request.

9. In the event my Agent is unable or unwilling to serve or to continue to serve, then I appoint

_____

Name of Successor Agent

of _____

Address *City* *State*

to serve as substitute or successor agent who shall have all the title, powers and discretion herein given my Agent.

10. My Agent is authorized to make photocopies of this instrument as frequently as necessary. All photocopies shall have the same force and effect as the original.

11. If any provision of this instrument or its application to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this instrument which can be given effect without the invalid provision or application, and to this end the provisions of this instrument are severable.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at _____,

this _____ day of _____, 19_____.

_____

Signature of Principal

_____

Name of Principal

Witnesses

_____ of _____

Signature of Witness *City* *State*

_____ of _____

Signature of Witness *City* *State*

STATE OF_____

COUNTY OF _____

On this _____ day of _____,

_____

in the year _____, before me, the undersigned, a Notary Public in and for said State personally appeared

_____, personally

_____

known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged to me that he/she executed the same. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and official seal.

_____

Notary Public

(Notary Seal)

_____

_____

The undersigned acknowledges and accepts appointment as Agent under this instrument on this _____

day of _____, in the year _____.

_____

Signature of Agent

_____

Name of Agent

DURABLE POWER OF ATTORNEY
("Springing" Power)

Created by _____ as Principal.

1. I, _____
Name of Principal

of _____,
Address *City* *State*

as principal (the "Principal") intend to create by this instrument a Durable Power of Attorney and do hereby appoint

_____ of
Name of Agent

_____
Address *City* *State*

("Agent") to act for me and in my name and exercise the powers set forth below.

2. My Agent is authorized in my Agent's sole and absolute discretion from time to time and at any time, with respect to any and all of my property and interests in property, real, personal, intangible and mixed, as follows:

(a) Real Property Transactions: To lease, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any interest in real property whatsoever, on such terms and conditions, and under such covenants, as my Agent shall deem proper; and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens, mortgage, subject to deeds of trust, and in any way or manner deal with all or any part of any interest in real property whatsoever, that I own at the time of execution or may thereafter acquire, for under such terms and conditions, and under such covenants, as my Agent shall deem proper; and, to supplement this instrument by adding or modifying the descriptions of any property, real or personal, which I may now or hereafter own, in whole or in part.

(b) Personal Property Transactions: To lease, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any personal property whatsoever, tangible or intangible, or interest thereto, on such terms and conditions, and under such covenants, as my Agent shall deem proper, and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens, mortgages, subject to deeds of trust, and hypothecate, and in any way or manner deal with all or any part of any real or personal property whatsoever, tangible or intangible, or any interest therein, that I own at the time or execution or may thereafter acquire, under such terms and conditions, and under such covenants, as my Agent shall deem proper.

(c) Bond, Share and Commodity Transactions: To request, ask, demand, sue for, recover, collect, receive, and hold and possess any bond, share, instrument or similar character, commodity interest or any instrument with respect thereto together with the interest, dividends, proceeds, or other distributions connected therewith, as now are, or shall hereafter become, owned by, or due, owing payable, or belonging to, me at the time of execution or in which I may thereafter acquire interest; to have, use, and take all lawful means and equitable and legal remedies, procedures, and writs in my name for the collection and recovery thereof, and to adjust, sell, compromise, and agree for the same, and to make, execute, and deliver for me, all endorsements, acquittances, releases, receipts, or other sufficient discharges for the same.

(d) Banking Transactions: To make, receive, sign, endorse, execute, acknowledge, deliver, and possess checks, drafts, bills of exchange, letters of credit, notes, stock certificates, withdrawal receipts and deposit instruments relating to accounts or deposits in, or certificates of deposit of, banks, savings and loan or other institutions or associations for me.

(e) Safe Deposits: To have free access at any time to any safe deposit box or vault to which I might have access; and to contract with any institution for the maintenance of a safe deposit box in my name; and to add to and remove from the contents of any such safe deposit box.

(f) Business Operating Transactions: To conduct, engage in, and transact any and all lawful business of whatever nature or kind for me; to continue the operation of any business I own or have an interest in; to sell, liquidate or close out such business at such time and upon such terms as my Agent shall deem appropriate; to represent me and to exercise any right or power I may have in any partnership whether as a general, special or limited partner; to exercise all rights with respect to any securities I may now own or acquire hereafter in any public corporation, including the right to sell, hypothecate, buy the same or different securities and to vote at all meetings of the stockholders.

(g) Insurance Transactions: To exercise or perform any act, power, duty, right or obligation whatsoever in regard to any contract of life, accident, health, disability or liability insurance of any combination of such insurance procured by or on behalf of me prior to execution; and to procure new, different or additional contracts of insurance for me and to designate the beneficiary of any such contract of insurance, provided, however, that the Agent himself cannot be such beneficiary unless the Agent is my spouse, child, grandchild, parent, brother or sister.

(h) Estate Transactions: To request, ask, demand, sue for, recover, collect, receive, and hold and possess all legacies, bequests, devises, as are, owned by, or due, owing, payable, or belonging to, me at the time of execution or in which I may thereafter acquire interest; to have, use, and take all lawful means and equitable and legal remedies, procedures, and writs in my name for the collection and recovery thereof; and to adjust, sell, compromise, and agree for the same, and to make, execute, and deliver for me, all endorsements, acquittances, releases, receipts, or other sufficient discharges for the same.

(i) Personal Relationships and Affairs: To do all acts necessary for maintaining the customary standard of living for me, my spouse and children, and other dependents; to provide medical, dental and surgical care, hospitalization and custodial care for me, my spouse, and children and other dependents; to continue whatever provision has been made by me, for me, my spouse, and children, and other dependents, with respect to automobiles, or other means of transportation; to continue whatever charge accounts have been operated by me, to open such new accounts as my Agent shall think to be desirable for the accomplishment of any of the purposes enumerated in this section, and to pay the items charged on such accounts by any person authorized or permitted by me or my Agent to make such charges; to continue the discharge of any services or duties assumed by me, to any parent, relative or friend of mine; to continue payments incidental to my membership or affiliation in any church, club, society, order or other organization, or to continue contributions thereto.

(j) Tax, Social Security and Unemployment: To prepare, execute and file all tax, social security, unemployment insurance and information returns for tax years between 1970 and 2020 required by the laws of the United States, or of any state or subdivision thereof, or of any foreign government; to prepare, execute and file all other papers and instruments which the Agent shall think to be desirable or necessary to safeguard me against excess or illegal taxation or against penalties imposed for claimed violation of any law or other governmental regulation; and to pay, compromise, contest or apply for refunds in connection with any taxes or assessments for which I am or may be liable.

(k) Benefits from Military Service: To execute vouchers in my name for any and all allowances and reimbursements payable by the United States, or subdivision thereof, to me, arising from or based upon military service and to receive, endorse and collect the proceeds of any check payable to me drawn on the treasurer or other fiscal officer or depository of the United States or subdivision thereof; to take possession and to order the removal and shipment, of any property belonging to me from any post, warehouse, depot, dock or other place of storage or safekeeping, either governmental or private; to execute and to deliver any release, voucher, receipt, bill of lading, shipping ticket, certificate or other instrument which the Agent shall think to be desirable or necessary for such purpose; to prepare, to file and to prosecute my claim to any benefit or assistance, financial or otherwise, to which I am or claim to be, entitled, under the provisions of any statute or regulation existing at the creation of the agency or thereafter enacted by the United States or by any state or by any subdivision thereof, or by any foreign government, which benefit or assistance arises from or is based upon military service performed prior to or after execution.

(l) Revocable Trust: To execute a revocable trust agreement with such trustee as my Agent shall select which trust shall pay to me or disburse on my behalf such amounts of income or principal as necessary for my proper health, support and maintenance, and that on my death any remaining income and principal shall be paid to my personal representative, and that said trust may be revoked or amended by me or my Agent at any time and from time to time, provided that any such amendment by my Agent shall not include any provision which could not be included in the original trust agreement; to deliver and convey any or all of my assets to the trustee thereof; to add any or all of my assets to such a trust already in existence at the time this instrument is executed or at any time thereafter.

3. This power of attorney shall become effective upon the disability or incapacity of the principal. Notwithstanding any provision herein to the contrary, my Agent shall take no action under this instrument unless I am deemed to be disabled or incapacitated as defined herein. My incapacity shall be deemed to exist when so certified in writing by two licensed physicians not related by blood or marriage to either me or to my Agent. The said certificate shall state that I am incapable of caring for myself and that I am physically and mentally incapable of managing my financial affairs. The certificate of the physicians described above shall be attached to the original of this instrument and if this instrument is filed or recorded among public records, then such certificate shall also be similarly filed or recorded if permitted by applicable law.

4. No person who acts in reliance upon any representations made by my Agent as to (a) the continued validity of the Durable Power of Attorney, (b) the scope of powers granted under this instrument, (c) my competency at the time this instrument was executed, or (d) the fact that this instrument has not been revoked, shall incur any liability to me, my estate, my heirs or assigns as a result of any dealings with my Agent, nor shall any person who deals with my Agent shall inquire into the proper application of funds or property.

5. I reserve unto myself the right to amend or revoke this instrument, and to remove my Agent and any alternate agent by executing a written instrument of revocation, amendment, or removal and delivering it to my Agent and to all alternate agents. If the instrument has been recorded in the public records, then the instrument of revocation, amendment or removal shall be filed or recorded in the same public records.

6. If my spouse has been appointed as my Agent herein, and subsequent to the execution of this instrument, legal proceedings are instituted for separation and dissolution of our marriage, institution of such proceedings shall automatically remove my spouse as my Agent.

7. My Agent shall be entitled to reimbursement for all reasonable costs actually incurred and paid by my Agent on my behalf under the authority granted in this instrument.

8. To the extent permitted by law, I herewith nominate, constitute and appoint my Agent to serve as my guardian, conservator and/or in any similar representative capacity; and, if I am not permitted by law to so nominate, constitute and appoint, then I request any court of competent jurisdiction which may be petitioned by any person to appoint a guardian, conservator or similar representative for me to give due consideration to my request.

9. In the event my Agent is unable or unwilling to serve or to continue to serve, then I appoint

_____

Name of Successor Agent

of _____

Address *City* *State*

to serve as substitute or successor agent who shall have all the title, powers and discretion herein given my Agent.

10. My Agent is authorized to make photocopies of this instrument as frequently as necessary. All photocopies shall have the same force and effect as the original.

11. If any provision of this instrument or its application to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this instrument which can be given effect without the invalid provision or application, and to this end the provisions of this instrument are severable.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at _____,

this _____ day of _____, 19_____.

_____
Signature of Principal

_____
Name of Principal

Witnesses

_____ of _____
Signature of Witness *City* *State*

_____ of _____
Signature of Witness *City* *State*

STATE OF_____

COUNTY OF _____

On this _____ day of _____;

_____

in the year _____, before me, the undersigned, a Notary Public in and for said State personally appeared

_____, personally

_____

known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged to me that he/she executed the same. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and official seal.

_____
Notary Public

(Notary Seal)

_____

_____

The undersigned acknowledges and accepts appointment as Agent under this instrument on this _____

day of _____, in the year _____.

_____
Signature of Agent

_____
Name of Agent

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(Immediate Power)

Created by _____ as Principal.

1. I, _____
Name of Principal

of _____,
Address *City* *State*

as principal (the "Principal") intend to create by this instrument a Durable Power of Attorney for health care and do hereby appoint

_____ of
Name of Agent

_____
Address *City* *State*

my Agent ("Agent") to act for me and in my name and exercise the powers set forth below in matters involving my health and medical care. Accordingly, my Agent is authorized as follows:

2. Subject to any limitations in this document, I hereby grant to my Agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my Agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my Agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

3. I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of health care, including hospitals, to release to my Agent all information contained in my medical records which my Agent may request. I hereby waive all privileges attached to physician-patient relationship and to any communication, verbal or written, arising out of such a relationship. My Agent is authorized to request, receive and review any information, verbal or written, pertaining to my physical or mental health, including medical and hospital records, and to execute any releases, waivers or other documents that may be required in order to obtain such information, and to disclose such information to such persons, organizations and health care providers as my Agent shall deem appropriate.

4. My Agent is authorized to employ and discharge health care providers including physicians, psychiatrists, dentists, nurses, and therapists as my Agent shall deem appropriate for my physical, mental and emotional well-being. My Agent is also authorized to pay reasonable fees and expenses for such services contracted.

5. My Agent is authorized to apply for my admission to a medical, nursing, residential or other similar facility, execute any consent or admission forms required by such facility and enter into agreements for my care at such facility or elsewhere during my lifetime or for such lesser periods of time as my Agent may designate.

6. My Agent is authorized to arrange for and consent to medical, therapeutical and surgical procedures for me including the administration of drugs. The power to make health care decisions for me shall include the power to give consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

7. I reserve unto myself the right to revoke the authority granted to my Agent hereunder to make health care decisions for me by notifying the treating physician, hospital, or other health care provider orally or in writing.

8. Notwithstanding any provision herein to the contrary, I retain the right to make medical and other health care decisions for myself so long as I am able to give informed consent with respect to a particular decision. In addition, no treatment may be given to me over my objection, and health care necessary to keep me alive may not be stopped if I object.

9. If at any time I should have a terminal condition and my attending physician and another physician, independently of each other, have determined that there can be no recovery from such condition and my death is imminent, where the application of life-prolonging procedures would serve only to artificially prolong 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 or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

For purposes of this declaration, life-prolonging procedure shall mean any medical procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process. "Life-prolonging procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

10. If I have been in an irreversible coma with no reasonable possibility of my ever regaining consciousness, I direct that all procedures used to provide me with nourishment and water (including, for instance, through intravenous feeding and through endotracheal or nasogastric tube means) not be instituted or, if already instituted, withdrawn.

11. This power of attorney shall not be affected by subsequent disability or incapacity of the principal.

12. My Agent shall be entitled to reimbursement for all reasonable costs actually incurred and paid by my Agent on my behalf under the authority granted in this instrument.

13. To the extent permitted by law, I herewith nominate, constitute and appoint my Agent to serve as my guardian, conservator and/or in any similar representative capacity; and, if I am not permitted by law to so nominate, constitute and appoint, then I request any court of competent jurisdiction which may be petitioned by any person to appoint a guardian, conservator or similar representative for me to give due consideration to my request.

14. In the event my Agent is unable or unwilling to serve or to continue to serve, then I appoint

_____
Name of Successor Agent

of _____
Address *City* *State*

to serve as substitute or successor agent who shall have all the title, powers and discretion herein given my Agent.

15. My Agent is authorized to make photocopies of this instrument as frequently as necessary. All photocopies shall have the same force and effect as the original.

16. If any provision of this instrument or its application to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this instrument which can be given effect without the invalid provision or application, and to this end the provisions of this instrument are severable.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at _____,

this _____ day of _____, 19_____.

_____
Signature of Principal

_____
Name of Principal

Witnesses

_____ of _____
Signature of Witness *City* *State*

_____ of _____
Signature of Witness *City* *State*

STATE OF _____

COUNTY OF _____

On this _____ day of _____,

_____

in the year _____, before me, the undersigned, a Notary Public in and for said State personally appeared

_____, personally

known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged to me that he/she executed the same. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and official seal.

_____
Notary Public

(Notary Seal)

_____

_____

The undersigned acknowledges and accepts appointment as Agent under this instrument on this _____ day of _____, in the year _____.

_____

Signature of Agent

_____

Name of Agent

DPA-4

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
("Springing" Power)

Created by _____ as Principal.

1. I, _____
Name of Principal

of _____,
Address *City* *State*

as principal (the "Principal") intend to create by this instrument a Durable Power of Attorney for health care and do hereby appoint

_____ of
Name of Agent

_____
Address *City* *State*

my Agent ("Agent") to act for me and in my name and exercise the powers set forth below in matters involving my health and medical care. Accordingly, my Agent is authorized as follows:

2. Subject to any limitations in this document, I hereby grant to my Agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my Agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my Agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

3. I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of health care, including hospitals, to release to my Agent all information contained in my medical records which my Agent may request. I hereby waive all privileges attached to physician-patient relationship and to any communication, verbal or written, arising out of such a relationship. My Agent is authorized to request, receive and review any information, verbal or written, pertaining to my physical or mental health, including medical and hospital records, and to execute any releases, waivers or other documents that may be required in order to obtain such information, and to disclose such information to such persons, organizations and health care providers as my Agent shall deem appropriate.

4. My Agent is authorized to employ and discharge health care providers including physicians, psychiatrists, dentists, nurses, and therapists as my Agent shall deem appropriate for my physical, mental and emotional well-being. My Agent is also authorized to pay reasonable fees and expenses for such services contracted.

5. My Agent is authorized to apply for my admission to a medical, nursing, residential or other similar facility, execute any consent or admission forms required by such facility and enter into agreements for my care at such facility or elsewhere during my lifetime or for such lesser periods of time as my Agent may designate.

6. My Agent is authorized to arrange for and consent to medical, therapeutical and surgical procedures for me including the administration of drugs. The power to make health care decisions for me shall include the power to give consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

7. I reserve unto myself the right to revoke the authority granted to my Agent hereunder to make health care decisions for me by notifying the treating physician, hospital, or other health care provider orally or in writing.

8. Notwithstanding any provision herein to the contrary, I retain the right to make medical and other health care decisions for myself so long as I am able to give informed consent with respect to a particular decision. In addition, no treatment may be given to me over my objection, and health care necessary to keep me alive may not be stopped if I object.

9. If at any time I should have a terminal condition and my attending physician and another physician, independently of each other, have determined that there can be no recovery from such condition and my death is imminent, where the application of life-prolonging procedures would serve only to artificially prolong 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 or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

For purposes of this declaration, life-prolonging procedure shall mean any medical procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process. "Life-prolonging procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

10. If I have been in an irreversible coma with no reasonable possibility of my ever regaining consciousness, I direct that all procedures used to provide me with nourishment and water (including, for instance, through intravenous feeding and through endotracheal or nasogastric tube means) not be instituted or, if already instituted, withdrawn.

11. This power of attorney shall become effective upon the disability or incapacity of the principal. Notwithstanding any provision herein to the contrary, my Agent shall take no action under this instrument unless I am deemed to be disabled or incapacitated as defined herein. My incapacity shall be deemed to exist when so certified in writing by two licensed physicians not related by blood or marriage to either me or to my Agent. The said certificate shall state that I am incapable of caring

for myself and that I am physically and mentally incapable of managing my financial affairs. The certificate of the physicians described above shall be attached to the original of this instrument and if this instrument is filed or recorded among public records, then such certificate shall also be similarly filed or recorded if permitted by applicable law.

12. My Agent shall be entitled to reimbursement for all reasonable costs actually incurred and paid by my Agent on my behalf under the authority granted in this instrument.

13. To the extent permitted by law, I herewith nominate, constitute and appoint my Agent to serve as my guardian, conservator and/or in any similar representative capacity; and, if I am not permitted by law to so nominate, constitute and appoint, then I request any court of competent jurisdiction which may be petitioned by any person to appoint a guardian, conservator or similar representative for me to give due consideration to my request.

14. In the event my Agent is unable or unwilling to serve or to continue to serve, then I appoint

_____
Name of Successor Agent

of _____
Address *City* *State*

to serve as substitute or successor agent who shall have all the title, powers and discretion herein given my Agent.

15. My Agent is authorized to make photocopies of this instrument as frequently as necessary. All photocopies shall have the same force and effect as the original.

16. If any provision of this instrument or its application to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this instrument which can be given effect without the invalid provision or application, and to this end the provisions of this instrument are severable.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at _____,

this _____ day of _____, 19_____.

_____
Signature of Principal

_____
Name of Principal

Witnesses

_____ of _____
Signature of Witness *City* *State*

_____ of _____
Signature of Witness *City* *State*

STATE OF _____

COUNTY OF _____

On this _____ day of _____,

_____

in the year _____, before me, the undersigned, a Notary Public in and for said State personally appeared

_____, personally

known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged to me that he/she executed the same. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and official seal.

_____
Notary Public

(Notary Seal)

_____

_____

The undersigned acknowledges and accepts appointment as Agent under this instrument on this _____ day of _____, in the year _____.

_____

Signature of Agent

_____

Name of Agent

DURABLE POWER OF ATTORNEY FOR ASSET MANAGEMENT AND HEALTH CARE
(Immediate Power)

Created by _____ as Principal.

1. I, _____
Name of Principal

of _____,
Address *City* *State*

as principal (the "Principal") intend to create by this instrument a Durable Power of Attorney and do hereby appoint

_____ of
Name of Agent

_____
Address *City* *State*

("Agent") to act for me and in my name and exercise the powers set forth below.

2. My Agent is authorized in my Agent's sole and absolute discretion from time to time and at any time, with respect to any and all of my property and interests in property, real, personal, intangible and mixed, as follows:

(a) Real Property Transactions: To lease, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any interest in real property whatsoever, on such terms and conditions, and under such covenants, as my Agent shall deem proper; and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens, mortgage, subject to deeds of trust, and in any way or manner deal with all or any part of any interest in real property whatsoever, that I own at the time of execution or may thereafter acquire, for under such terms and conditions, and under such covenants, as my Agent shall deem proper; and, to supplement this instrument by adding or modifying the descriptions of any property, real or personal, which I may now or hereafter own, in whole or in part.

(b) Personal Property Transactions: To lease, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any personal property whatsoever, tangible or intangible, or interest thereto, on such terms and conditions, and under such covenants, as my Agent shall deem proper, and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens, mortgages, subject to deeds of trust, and hypothecate, and in any way or manner deal with all or any part of any real or personal property whatsoever, tangible or intangible, or any interest therein, that I own at the time or execution or may thereafter acquire, under such terms and conditions, and under such covenants, as my Agent shall deem proper.

(c) Bond, Share and Commodity Transactions: To request, ask, demand, sue for, recover, collect, receive, and hold and possess any bond, share, instrument or similar character, commodity interest or any instrument with respect thereto together with the interest, dividends, proceeds, or other distributions connected therewith, as now are, or shall hereafter become, owned by, or due, owing payable, or belonging to, me at the time of execution or in which I may thereafter acquire interest; to have, use, and take all lawful means and equitable and legal remedies, procedures, and writs in my name for the collection and recovery thereof, and to adjust, sell, compromise, and agree for the same, and to make, execute, and deliver for me, all endorsements, acquittances, releases, receipts, or other sufficient discharges for the same.

(d) Banking Transactions: To make, receive, sign, endorse, execute, acknowledge, deliver, and possess checks, drafts, bills of exchange, letters of credit, notes, stock certificates, withdrawal receipts and deposit instruments relating to accounts or deposits in, or certificates of deposit of, banks, savings and loan or other institutions or associations for me.

(e) Safe Deposits: To have free access at any time to any safe deposit box or vault to which I might have access; and to contract with any institution for the maintenance of a safe deposit box in my name; and to add to and remove from the contents of any such safe deposit box.

(f) Business Operating Transactions: To conduct, engage in, and transact any and all lawful business of whatever nature or kind for me; to continue the operation of any business I own or have an interest in; to sell, liquidate or close out such business at such time and upon such terms as my Agent shall deem appropriate; to represent me and to exercise any right or power I may have in any partnership whether as a general, special or limited partner; to exercise all rights with respect to any securities I may now own or acquire hereafter in any public corporation, including the right to sell, hypothecate, buy the same or different securities and to vote at all meetings of the stockholders.

(g) Insurance Transactions: To exercise or perform any act, power, duty, right or obligation whatsoever in regard to any contract of life, accident, health, disability or liability insurance of any combination of such insurance procured by or on behalf of me prior to execution; and to procure new, different or additional contracts of insurance for me and to designate the beneficiary of any such contract of insurance, provided, however, that the Agent himself cannot be such beneficiary unless the Agent is my spouse, child, grandchild, parent, brother or sister.

(h) Estate Transactions: To request, ask, demand, sue for, recover, collect, receive, and hold and possess all legacies, bequests, devises, as are, owned by, or due, owing, payable, or belonging to, me at the time of execution or in which I may thereafter acquire interest; to have, use, and take all lawful means and equitable and legal remedies, procedures, and writs in my name for the collection and recovery thereof; and to adjust, sell, compromise, and agree for the same, and to make, execute, and deliver for me, all endorsements, acquittances, releases, receipts, or other sufficient discharges for the same.

(i) Personal Relationships and Affairs: To do all acts necessary for maintaining the customary standard of living for me, my spouse and children, and other dependents; to provide medical, dental and surgical care, hospitalization and custodial care for me, my spouse, and children and other dependents; to continue whatever provision has been made by me, for me, my spouse, and children, and other dependents, with respect to automobiles, or other means of transportation; to continue whatever charge accounts have been operated by me, to open such new accounts as my Agent shall think to be desirable for the accomplishment of any of the purposes enumerated in this section, and to pay the items charged on such accounts by any person authorized or permitted by me or my Agent to make such charges; to continue the discharge of any services or duties assumed by me, to any parent, relative or friend of mine; to continue payments incidental to my membership or affiliation in any church, club, society, order or other organization, or to continue contributions thereto.

(j) Tax, Social Security and Unemployment: To prepare, execute and file all tax, social security, unemployment insurance and information returns for tax years between 1970 and 2020 required by the laws of the United States, or of any state or subdivision thereof, or of any foreign government; to prepare, execute and file all other papers and instruments which the Agent shall think to be desirable or necessary to safeguard me against excess or illegal taxation or against penalties imposed for claimed violation of any law or other governmental regulation; and to pay, compromise, contest or apply for refunds in connection with any taxes or assessments for which I am or may be liable.

(k) Benefits from Military Service: To execute vouchers in my name for any and all allowances and reimbursements payable by the United States, or subdivision thereof, to me, arising from or based upon military service and to receive, endorse and collect the proceeds of any check payable to me drawn on the treasurer or other fiscal officer or depository of the United States or subdivision thereof; to take possession and to order the removal and shipment, of any property belonging to me from any post, warehouse, depot, dock or other place of storage or safekeeping, either governmental or private; to execute and to deliver any release, voucher, receipt, bill of lading, shipping ticket, certificate or other instrument which the Agent shall think to be desirable or necessary for such purpose; to prepare, to file and to prosecute my claim to any benefit or assistance, financial or otherwise, to which I am or claim to be, entitled, under the provisions of any statute or regulation existing at the creation of the agency or thereafter enacted by the United States or by any state or by any subdivision thereof, or by any foreign government, which benefit or assistance arises from or is based upon military service performed prior to or after execution.

(l) Revocable Trust: To execute a revocable trust agreement with such trustee as my Agent shall select which trust shall pay to me or disburse on my behalf such amounts of income or principal as necessary for my proper health, support and maintenance, and that on my death any remaining income and principal shall be paid to my personal representative, and that said trust may be revoked or amended by me or my Agent at any time and from time to time, provided that any such amendment by my Agent shall not include any provision which could not be included in the original trust agreement; to deliver and convey any or all of my assets to the trustee thereof; to add any or all of my assets to such a trust already in existence at the time this instrument is executed or at any time thereafter.

2.1 With respect to matters involving my health and medical care, my Agent is authorized as follows:

(a) Subject to any limitations in this document, I hereby grant to my Agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my Agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my Agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

(b) I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of health care, including hospitals, to release to my Agent all information contained in my medical records which my Agent may request. I hereby waive all privileges attached to physician-patient relationship and to any communication, verbal or written, arising out of such a relationship. My Agent is authorized to request, receive and review any information, verbal or written, pertaining to my physical or mental health, including medical and hospital records, and to execute any releases, waivers or other documents that may be required in order to obtain such information, and to disclose such information to such persons, organizations and health care providers as my Agent shall deem appropriate.

(c) My Agent is authorized to employ and discharge health care providers including physicians, psychiatrists, dentists, nurses, and therapists as my Agent shall deem appropriate for my physical, mental and emotional well-being. My Agent is also authorized to pay reasonable fees and expenses for such services contracted.

(d) My Agent is authorized to apply for my admission to a medical, nursing, residential or other similar facility, execute any consent or admission forms required by such facility and enter into agreements for my care at such facility or elsewhere during my lifetime or for such lesser periods of time as my Agent may designate.

(e) My Agent is authorized to arrange for and consent to medical, therapeutical and surgical procedures for me including the administration of drugs. The power to make health care decisions for me shall include the power to give consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

(f) I reserve unto myself the right to revoke the authority granted to my Agent hereunder to make health care decisions for me by notifying the treating physician, hospital, or other health care provider orally or in writing.

(g) Notwithstanding any provision herein to the contrary, I retain the right to make medical and other health care decisions for myself so long as I am able to give informed consent with respect to a particular decision. In addition, no treatment may be given to me over my objection, and health care necessary to keep me alive may not be stopped if I object.

(h) If at any time I should have a terminal condition and my attending physician and another physician, independently of each other, have determined that there can be no recovery from such condition and my death is imminent, where the application of life-prolonging procedures would serve only to artificially prolong 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 or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

For purposes of this declaration, life-prolonging procedure shall mean any medical procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process. "Life-prolonging procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

(i) If I have been in an irreversible coma with no reasonable possibility of my ever regaining consciousness, I direct that all procedures used to provide me with nourishment and water (including, for instance, through intravenous feeding and through endotracheal or nasogastric tube means) not be instituted or, if already instituted, withdrawn.

3. This power of attorney shall not be affected by subsequent disability or incapacity of the principal.

4. No person who acts in reliance upon any representations made by my Agent as to (a) the continued validity of the Durable Power of Attorney, (b) the scope of powers granted under this instrument, (c) my competency at the time this instrument was executed, or (d) the fact that this instrument has not been revoked, shall incur any liability to me, my estate, my heirs or assigns as a result of any dealings with my Agent, nor shall any person who deals with my Agent shall inquire into the proper application of funds or property.

5. I reserve unto myself the right to amend or revoke this instrument, and to remove my Agent and any alternate agent by executing a written instrument of revocation, amendment, or removal and delivering it to my Agent and to all alternate agents. If the instrument has been recorded in the public records, then the instrument of revocation, amendment or removal shall be filed or recorded in the same public records.

6. If my spouse has been appointed as my Agent herein, and subsequent to the execution of this instrument, legal proceedings are instituted for separation and dissolution of our marriage, institution of such proceedings shall automatically remove my spouse as my Agent.

7. My Agent shall be entitled to reimbursement for all reasonable costs actually incurred and paid by my Agent on my behalf under the authority granted in this instrument.

8. To the extent permitted by law, I herewith nominate, constitute and appoint my Agent to serve as my guardian, conservator and/or in any similar representative capacity; and, if I am not permitted by law to so nominate, constitute and appoint, then I request any court of competent jurisdiction which may be petitioned by any person to appoint a guardian, conservator or similar representative for me to give due consideration to my request.

9. In the event my Agent is unable or unwilling to serve or to continue to serve, then I appoint

_____
Name of Successor Agent

of _____
Address *City* *State*

to serve as substitute or successor agent who shall have all the title, powers and discretion herein given my Agent.

10. My Agent is authorized to make photocopies of this instrument as frequently as necessary. All photocopies shall have the same force and effect as the original.

11. If any provision of this instrument or its application to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this instrument which can be given effect without the invalid provision or application, and to this end the provisions of this instrument are severable.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at _____,

this _____ day of _____, 19_____.

_____
Signature of Principal

_____
Name of Principal

Witnesses

_____ of _____
Signature of Witness *City* *State*

_____ of _____
Signature of Witness *City* *State*

STATE OF_____

COUNTY OF _____

On this _____ day of _____,

_____

in the year _____, before me, the undersigned, a Notary Public in and for said State personally appeared

_____, personally

_____

known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged to me that he/she executed the same. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and official seal.

_____

Notary Public

(Notary Seal)

_____

_____

The undersigned acknowledges and accepts appointment as Agent under this instrument on this _____

day of _____, in the year _____.

_____

Signature of Agent

_____

Name of Agent

DURABLE POWER OF ATTORNEY FOR ASSET MANAGEMENT AND HEALTH CARE
("Springing" Power)

Created by _____ as Principal.

1. I, _____
Name of Principal

of _____,
Address *City* *State*

as principal (the "Principal") intend to create by this instrument a Durable Power of Attorney and do hereby appoint

_____ of
Name of Agent

_____
Address *City* *State*

("Agent") to act for me and in my name and exercise the powers set forth below.

2. My Agent is authorized in my Agent's sole and absolute discretion from time to time and at any time, with respect to any and all of my property and interests in property, real, personal, intangible and mixed, as follows:

(a) Real Property Transactions: To lease, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any interest in real property whatsoever, on such terms and conditions, and under such covenants, as my Agent shall deem proper; and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens, mortgage, subject to deeds of trust, and in any way or manner deal with all or any part of any interest in real property whatsoever, that I own at the time of execution or may thereafter acquire, for under such terms and conditions, and under such covenants, as my Agent shall deem proper; and, to supplement this instrument by adding or modifying the descriptions of any property, real or personal, which I may now or hereafter own, in whole or in part.

(b) Personal Property Transactions: To lease, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any personal property whatsoever, tangible or intangible, or interest thereto, on such terms and conditions, and under such covenants, as my Agent shall deem proper, and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens, mortgages, subject to deeds of trust, and hypothecate, and in any way or manner deal with all or any part of any real or personal property whatsoever, tangible or intangible, or any interest therein, that I own at the time or execution or may thereafter acquire, under such terms and conditions, and under such covenants, as my Agent shall deem proper.

(c) Bond, Share and Commodity Transactions: To request, ask, demand, sue for, recover, collect, receive, and hold and possess any bond, share, instrument or similar character, commodity interest or any instrument with respect thereto together with the interest, dividends, proceeds, or other distributions connected therewith, as now are, or shall hereafter become, owned by, or due, owing payable, or belonging to, me at the time of execution or in which I may thereafter acquire interest; to have, use, and take all lawful means and equitable and legal remedies, procedures, and writs in my name for the collection and recovery thereof, and to adjust, sell, compromise, and agree for the same, and to make, execute, and deliver for me, all endorsements, acquittances, releases, receipts, or other sufficient discharges for the same.

(d) Banking Transactions: To make, receive, sign, endorse, execute, acknowledge, deliver, and possess checks, drafts, bills of exchange, letters of credit, notes, stock certificates, withdrawal receipts and deposit instruments relating to accounts or deposits in, or certificates of deposit of, banks, savings and loan or other institutions or associations for me.

(e) Safe Deposits: To have free access at any time to any safe deposit box or vault to which I might have access; and to contract with any institution for the maintenance of a safe deposit box in my name; and to add to and remove from the contents of any such safe deposit box.

(f) Business Operating Transactions: To conduct, engage in, and transact any and all lawful business of whatever nature or kind for me; to continue the operation of any business I own or have an interest in; to sell, liquidate or close out such business at such time and upon such terms as my Agent shall deem appropriate; to represent me and to exercise any right or power I may have in any partnership whether as a general, special or limited partner; to exercise all rights with respect to any securities I may now own or acquire hereafter in any public corporation, including the right to sell, hypothecate, buy the same or different securities and to vote at all meetings of the stockholders.

(g) Insurance Transactions: To exercise or perform any act, power, duty, right or obligation whatsoever in regard to any contract of life, accident, health, disability or liability insurance of any combination of such insurance procured by or on behalf of me prior to execution; and to procure new, different or additional contracts of insurance for me and to designate the beneficiary of any such contract of insurance, provided, however, that the Agent himself cannot be such beneficiary unless the Agent is my spouse, child, grandchild, parent, brother or sister.

(h) Estate Transactions: To request, ask, demand, sue for, recover, collect, receive, and hold and possess all legacies, bequests, devises, as are, owned by, or due, owing, payable, or belonging to, me at the time of execution or in which I may thereafter acquire interest; to have, use, and take all lawful means and equitable and legal remedies, procedures, and writs in my name for the collection and recovery thereof; and to adjust, sell, compromise, and agree for the same, and to make, execute, and deliver for me, all endorsements, acquittances, releases, receipts, or other sufficient discharges for the same.

(i) Personal Relationships and Affairs: To do all acts necessary for maintaining the customary standard of living for me, my spouse and children, and other dependents; to provide medical, dental and surgical care, hospitalization and custodial care for me, my spouse, and children and other dependents; to continue whatever provision has been made by me, for me, my spouse, and children, and other dependents, with respect to automobiles, or other means of transportation; to continue whatever charge accounts have been operated by me, to open such new accounts as my Agent shall think to be desirable for the accomplishment of any of the purposes enumerated in this section, and to pay the items charged on such accounts by any person authorized or permitted by me or my Agent to make such charges; to continue the discharge of any services or duties assumed by me, to any parent, relative or friend of mine; to continue payments incidental to my membership or affiliation in any church, club, society, order or other organization, or to continue contributions thereto.

(j) Tax, Social Security and Unemployment: To prepare, execute and file all tax, social security, unemployment insurance and information returns for tax years between 1970 and 2020 required by the laws of the United States, or of any state or subdivision thereof, or of any foreign government; to prepare, execute and file all other papers and instruments which the Agent shall think to be desirable or necessary to safeguard me against excess or illegal taxation or against penalties imposed for claimed violation of any law or other governmental regulation; and to pay, compromise, contest or apply for refunds in connection with any taxes or assessments for which I am or may be liable.

(k) Benefits from Military Service: To execute vouchers in my name for any and all allowances and reimbursements payable by the United States, or subdivision thereof, to me, arising from or based upon military service and to receive, endorse and collect the proceeds of any check payable to me drawn on the treasurer or other fiscal officer or depository of the United States or subdivision thereof; to take possession and to order the removal and shipment, of any property belonging to me from any post, warehouse, depot, dock or other place of storage or safekeeping, either governmental or private; to execute and to deliver any release, voucher, receipt, bill of lading, shipping ticket, certificate or other instrument which the Agent shall think to be desirable or necessary for such purpose; to prepare, to file and to prosecute my claim to any benefit or assistance, financial or otherwise, to which I am or claim to be, entitled, under the provisions of any statute or regulation existing at the creation of the agency or thereafter enacted by the United States or by any state or by any subdivision thereof, or by any foreign government, which benefit or assistance arises from or is based upon military service performed prior to or after execution.

(l) Revocable Trust: To execute a revocable trust agreement with such trustee as my Agent shall select which trust shall pay to me or disburse on my behalf such amounts of income or principal as necessary for my proper health, support and maintenance, and that on my death any remaining income and principal shall be paid to my personal representative, and that said trust may be revoked or amended by me or my Agent at any time and from time to time, provided that any such amendment by my Agent shall not include any provision which could not be included in the original trust agreement; to deliver and convey any or all of my assets to the trustee thereof; to add any or all of my assets to such a trust already in existence at the time this instrument is executed or at any time thereafter.

2.1 With respect to matters involving my health and medical care, my Agent is authorized as follows:

(a) Subject to any limitations in this document, I hereby grant to my Agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my Agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my Agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

(b) I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of health care, including hospitals, to release to my Agent all information contained in my medical records which my Agent may request. I hereby waive all privileges attached to physician-patient relationship and to any communication, verbal or written, arising out of such a relationship. My Agent is authorized to request, receive and review any information, verbal or written, pertaining to my physical or mental health, including medical and hospital records, and to execute any releases, waivers or other documents that may be required in order to obtain such information, and to disclose such information to such persons, organizations and health care providers as my Agent shall deem appropriate.

(c) My Agent is authorized to employ and discharge health care providers including physicians, psychiatrists, dentists, nurses, and therapists as my Agent shall deem appropriate for my physical, mental and emotional well-being. My Agent is also authorized to pay reasonable fees and expenses for such services contracted.

(d) My Agent is authorized to apply for my admission to a medical, nursing, residential or other similar facility, execute any consent or admission forms required by such facility and enter into agreements for my care at such facility or elsewhere during my lifetime or for such lesser periods of time as my Agent may designate.

(e) My Agent is authorized to arrange for and consent to medical, therapeutical and surgical procedures for me including the administration of drugs. The power to make health care decisions for me shall include the power to give consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

(f) I reserve unto myself the right to revoke the authority granted to my Agent hereunder to make health care decisions for me by notifying the treating physician, hospital, or other health care provider orally or in writing.

(g) Notwithstanding any provision herein to the contrary, I retain the right to make medical and other health care decisions for myself so long as I am able to give informed consent with respect to a particular decision. In addition, no treatment may be given to me over my objection, and health care necessary to keep me alive may not be stopped if I object.

(h) If at any time I should have a terminal condition and my attending physician and another physician, independently of each other, have determined that there can be no recovery from such condition and my death is imminent, where the application of life-prolonging procedures would serve only to artificially prolong 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 or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

For purposes of this declaration, life-prolonging procedure shall mean any medical procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process. "Life-prolonging procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

(i) If I have been in an irreversible coma with no reasonable possibility of my ever regaining consciousness, I direct that all procedures used to provide me with nourishment and water (including, for instance, through intravenous feeding and through endotracheal or nasogastric tube means) not be instituted or, if already instituted, withdrawn.

3. This power of attorney shall become effective upon the disability or incapacity of the principal. Notwithstanding any provision herein to the contrary, my Agent shall take no action under this instrument unless I am deemed to be disabled or incapacitated as defined herein. My incapacity shall be deemed to exist when so certified in writing by two licensed physicians not related by blood or marriage to either me or to my Agent. The said certificate shall state that I am incapable of caring for myself and that I am physically and mentally incapable of managing my financial affairs. The certificate of the physicians described above shall be attached to the original of this instrument and if this instrument is filed or recorded among public records, then such certificate shall also be similarly filed or recorded if permitted by applicable law.

4. No person who acts in reliance upon any representations made by my Agent as to (a) the continued validity of the Durable Power of Attorney, (b) the scope of powers granted under this instrument, (c) my competency at the time this instrument was executed, or (d) the fact that this instrument has not been revoked, shall incur any liability to me, my estate, my heirs or assigns as a result of any dealings with my Agent, nor shall any person who deals with my Agent shall inquire into the proper application of funds or property.

5. I reserve unto myself the right to amend or revoke this instrument, and to remove my Agent and any alternate agent by executing a written instrument of revocation, amendment, or removal and delivering it to my Agent and to all alternate agents. If the instrument has been recorded in the public records, then the instrument of revocation, amendment or removal shall be filed or recorded in the same public records.

6. If my spouse has been appointed as my Agent herein, and subsequent to the execution of this instrument, legal proceedings are instituted for separation and dissolution of our marriage, institution of such proceedings shall automatically remove my spouse as my Agent.

7. My Agent shall be entitled to reimbursement for all reasonable costs actually incurred and paid by my Agent on my behalf under the authority granted in this instrument.

8. To the extent permitted by law, I herewith nominate, constitute and appoint my Agent to serve as my guardian, conservator and/or in any similar representative capacity; and, if I am not permitted by law to so nominate, constitute and appoint, then I request any court of competent jurisdiction which may be petitioned by any person to appoint a guardian, conservator or similar representative for me to give due consideration to my request.

9. In the event my Agent is unable or unwilling to serve or to continue to serve, then I appoint

_____
Name of Successor Agent

of _____
Address *City* *State*

to serve as substitute or successor agent who shall have all the title, powers and discretion herein given my Agent.

10. My Agent is authorized to make photocopies of this instrument as frequently as necessary. All photocopies shall have the same force and effect as the original.

11. If any provision of this instrument or its application to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this instrument which can be given effect without the invalid provision or application, and to this end the provisions of this instrument are severable.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at _____,

this _____ day of _____, 19_____.

_____
Signature of Principal

_____
Name of Principal

Witnesses

_____ of _____
Signature of Witness *City* *State*

_____ of _____
Signature of Witness *City* *State*

STATE OF _____

COUNTY OF _____

On this _____ day of _____,

_____

in the year _____, before me, the undersigned, a Notary Public in and for said State personally appeared

_____, personally

_____

known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged to me that he/she executed the same. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and official seal.

_____

Notary Public

(Notary Seal)

_____

_____

The undersigned acknowledges and accepts appointment as Agent under this instrument on this _____

day of _____, in the year _____.

_____

Signature of Agent

_____

Name of Agent

STATUTORY SHORT FORM POWER OF ATTORNEY
(California Civil Code Section 2450)

WARNING. UNLESS YOU LIMIT THE POWER IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER TO ACT FOR YOU IN ANY WAY YOU COULD ACT FOR YOURSELF. FOR EXAMPLE, YOUR AGENT CAN:

—BUY, SELL, AND MANAGE REAL AND PERSONAL PROPERTY FOR YOU. THIS MEANS THAT YOUR AGENT CAN SELL YOUR HOME, YOUR SECURITIES, AND YOUR OTHER PROPERTY.

—DEPOSIT AND WITHDRAW MONEY FROM YOUR CHECKING AND SAVINGS ACCOUNTS.

—BORROW MONEY USING YOUR PROPERTY AS SECURITY FOR THE LOAN.

—PUT THINGS IN AND TAKE THINGS OUT OF YOUR SAFETY DEPOSIT BOX.

—OPERATE YOUR BUSINESS FOR YOU.

—PREPARE AND FILE TAX RETURNS FOR YOU AND ACT FOR YOU IN TAX MATTERS.

—ESTABLISH TRUSTS FOR YOU AND TAKE OTHER ACTIONS FOR YOU IN CONNECTION WITH PROBATE AND ESTATE PLANNING MATTERS.

—PROVIDE FOR THE SUPPORT AND WELFARE OF YOUR SPOUSE, CHILDREN, AND DEPENDENTS.

—CONTINUE PAYMENTS TO THE CHURCH AND OTHER ORGANIZATIONS OF WHICH YOU ARE A MEMBER AND MAKE GIFTS TO YOUR SPOUSE, DESCENDANTS, AND CHARITIES.

THIS DOCUMENT DOES NOT AUTHORIZE YOUR AGENT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOU. YOU CAN DESIGNATE AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU ONLY BY A SEPARATE DOCUMENT.

IT MAY BE IN YOUR BEST INTEREST TO CONSULT WITH A CALIFORNIA LAWYER BECAUSE THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE DEFINED IN SECTIONS 2460 TO 2473, INCLUSIVE, OF THE CALIFORNIA CIVIL CODE.

THE POWERS GRANTED BY THIS DOCUMENT WILL EXIST FOR AN INDEFINITE PERIOD OF TIME UNLESS YOU LIMIT THEIR DURATION IN THIS DOCUMENT. THESE POWERS WILL CONTINUE TO EXIST NOTWITHSTANDING YOUR SUBSEQUENT DISABILITY OR INCAPACITY UNLESS YOU INDICATE OTHERWISE IN THIS DOCUMENT.

YOU CAN ELIMINATE POWERS OF YOUR AGENT BY CROSSING OUT ANY ONE OR MORE OF THE POWERS LISTED IN PARAGRAPH 3 OF THIS FORM. YOU CAN WRITE OTHER LIMITATIONS AND SPECIAL PROVISIONS IN PARAGRAPH 4 OF THIS FORM. HOWEVER, IF YOU DO NOT WANT TO GRANT YOUR AGENT THE POWER TO ACT FOR YOU IN ANY WAY YOU COULD ACT FOR YOURSELF, IT MAY BE IN YOUR BEST INTEREST TO CONSULT WITH A LAWYER INSTEAD OF USING THIS FORM.

THIS DOCUMENT MUST BE SIGNED BY TWO WITNESSES AND BE NOTARIZED TO BE VALID.

YOU HAVE THE RIGHT TO REVOKE OR TERMINATE THIS POWER OF ATTORNEY.

YOU ARE NOT REQUIRED TO USE THIS FORM; YOU MAY USE A DIFFERENT POWER OF ATTORNEY IF THAT IS DESIRED BY THE PARTIES CONCERNED.

IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT YOU.

1. DESIGNATION OF AGENT.

I, _____
(Insert your name and address)

do hereby appoint _____

_____
(Insert name and address of your agent, or each agent if you want to designate more than one)

as my attorney(s) in fact (agent) to act for me and in my name as authorized in this document.

2. **CREATION OF DURABLE POWER OF ATTORNEY.** By this document I intend to create a general power of attorney under Sections 2450 to 2473, inclusive, of the California Civil Code. Subject to any limitations in this document, this power of attorney is a durable power of attorney and shall not be affected by my subsequent incapacity.

(If you want this power of attorney to terminate automatically when you lack capacity, you must so state in paragraph 4 ("Special Provisions and Limitations") below.)

3. **STATEMENT OF AUTHORITY GRANTED.** Subject to any limitations in this document, I hereby grant to my agent(s)

full power and authority to act for me and in my name, in any way which I myself could act, if I were personally present and able to act, with respect to the following matters as each of them is defined in Chapter 3 (commencing with Section 2450) of Title 9 of Part 4 of Division 3 of the California Civil Code to the extent that I am permitted by law to act through an agent:

(1) Real estate transactions.

(2) Tangible personal property transactions.

(3) Bond, share, and commodity transactions.

(4) Financial institution transactions.

(5) Business operating transactions.

(6) Insurance transactions.

(7) Retirement plan transactions.

(8) Estate transactions.

(9) Claims and litigation.

(10) Tax matters.

(11) Personal relationships and affairs.

(12) Benefits from military service.

(13) Records, reports, and statements.

(14) Full and unqualified authority to my agent(s) to delegate any or all of the foregoing powers to any person or persons whom my agent(s) shall select.

(15) All other matters.

(Strike out any one or more of the items above to which you do NOT desire to give your agent authority. Such elimination of any one or more of items (1) to (14), inclusive, automatically constitutes an elimination of item (15). TO STRIKE OUT AN ITEM, YOU MUST DRAW A LINE THROUGH THE TEXT OF THAT ITEM.)

4. **SPECIAL PROVISIONS AND LIMITATIONS.** In exercising the authority under this power of attorney, my agent(s) is subject to the following special provisions and limitations:

_____

_____

_____

_____

_____

_____

(Special provisions and limitations may be included in the statutory short form power of attorney only if they conform to the requirements of Section 2455 of the California Civil Code.)

5. **EXERCISE OF POWER OF ATTORNEY WHERE MORE THAN ONE AGENT DESIGNATED.** If I have designated more than one agent, the agents are to act _____.

(If you designate more than one agent and wish each agent alone to be able to exercise this power, insert in this blank the word "severally." Failure to make an insertion or the insertion of the word "jointly" will require that the agents act jointly.)

6. **DURATION.**

(The powers granted by this document will exist for an indefinite period of time unless you limit their duration below.)

This power of attorney expires on _____

_____

(Fill in this space ONLY if you want the authority of your agent to terminate before your death.)

7. **NOMINATION OF CONSERVATOR OF ESTATE.**

(A conservator of the estate may be appointed for you if a court decides that one should be appointed. The conservator is responsible for the management of your financial affairs and your property. You are not required to nominate a conservator but you may do so. The court will appoint the person you nominate unless that would be contrary to your best interests. You may, but are not required to, nominate as your conservator the same person you named in paragraph 1 as your agent. You may nominate a person as your conservator by completing the space below.)

If a conservator of the estate is to be appointed for me, I nominate the following person to serve as conservator of the estate

_____

_____

(Insert name and address of person nominated as conservator of the estate.)

DATE AND SIGNATURE OF PRINCIPAL

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Short Form Power of Attorney on _____

_____ at _____, _____.
Date *City* *State*

_____
(You sign here)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS BOTH (1) SIGNED BY TWO ADULT WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE AND (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC IN CALIFORNIA.)

STATEMENT OF WITNESSES

(READ CAREFULLY BEFORE SIGNING. You can sign as a witness only if you personally know the principal or the identity of the principal is proved to you by convincing evidence.)

(To have convincing evidence of the identity of the principal, you must be presented with and reasonably rely on any one or more of the following:

(1) An identification card or driver's license issued by the California Department of Motor Vehicles that is current or has been issued within five years.

(2) A passport issued by the Department of State of the United States that is current or has been issued within five years.

(3) Any of the following documents if the document is current or has been issued within five years and contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number:

(a) A passport issued by a foreign government that has been stamped by the United States Immigration and Naturalization Service.

(b) A driver's license issued by a state other than California or by a Canadian or Mexican public agency authorized to issue drivers' licenses.

(c) An identification card issued by a state other than California.

(d) An identification card issued by any branch of the armed forces of the United States.)

(Other kinds of proof of identity are not allowed.)

I declare under penalty of perjury under the laws of California that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this power of attorney in my presence, and that the principal appears to be of sound mind and under no duress, fraud, or undue influence.

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

Signature: _____ Residence Address: _____

Print Name: _____ _____

Date: _____ _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

State of California
County of _____ } ss.

On this _____ day of _____, in the year _____, before me, _____
(Insert name of notary public)

personally appeared _____,
(Insert name of principal)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it.

NOTARY SEAL

_____
(Signature of Notary Public)

STATUTORY FORM DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(California Civil Code Section 2500)

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT WHICH IS AUTHORIZED BY THE KEENE HEALTH CARE AGENT ACT. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT (THE ATTORNEY IN FACT) THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. YOUR AGENT MUST ACT CONSISTENTLY WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN.

EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT NECESSARY TO KEEP YOU ALIVE.

NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION AT THE TIME, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT AT THE TIME.

THIS DOCUMENT GIVES YOUR AGENT AUTHORITY TO CONSENT, TO REFUSE TO CONSENT, OR TO WITHDRAW CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. THIS POWER IS SUBJECT TO ANY STATEMENT OF YOUR DESIRES AND ANY LIMITATIONS THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT THAT YOU DO NOT DESIRE. IN ADDITION, A COURT CAN TAKE AWAY THE POWER OF YOUR AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOUR AGENT (1) AUTHORIZES ANYTHING THAT IS ILLEGAL, (2) ACTS CONTRARY TO YOUR KNOWN DESIRES, OR (3) WHERE YOUR DESIRES ARE NOT KNOWN, DOES ANYTHING THAT IS CLEARLY CONTRARY TO YOUR BEST INTERESTS.

UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST FOR SEVEN YEARS FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF AT THE TIME WHEN THIS SEVEN—YEAR PERIOD ENDS, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY OF YOUR AGENT BY NOTIFYING YOUR AGENT OR YOUR TREATING DOCTOR, HOSPITAL, OR OTHER HEALTH CARE PROVIDER ORALLY OR IN WRITING OF THE REVOCATION.

YOUR AGENT HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

UNLESS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER AFTER YOU DIE TO (1) AUTHORIZE AN AUTOPSY, (2) DONATE YOUR BODY OR PARTS THEREOF FOR TRANSPLANT OR THERAPEUTIC OR EDUCATIONAL OR SCIENTIFIC PURPOSES, AND (3) DIRECT THE DISPOSITION OF YOUR REMAINS.

THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

YOU SHOULD CAREFULLY READ AND FOLLOW THE WITNESSING PROCEDURE, DESCRIBED AT THE END OF THIS FORM. THIS DOCUMENT WILL NOT BE VALID UNLESS YOU COMPLY WITH THE WITNESSING PROCEDURE.

IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

YOUR AGENT MAY NEED THIS DOCUMENT IMMEDIATELY IN CASE OF AN EMERGENCY THAT REQUIRES A DECISION CONCERNING YOUR HEALTH CARE. EITHER KEEP THIS DOCUMENT WHERE IT IS IMMEDIATELY AVAILABLE TO YOUR AGENT AND ALTERNATE AGENTS OR GIVE EACH OF THEM AN EXECUTED COPY OF THIS DOCUMENT. YOU MAY ALSO WANT TO GIVE YOUR DOCTOR AN EXECUTED COPY OF THIS DOCUMENT.

DO NOT USE THIS FORM IF YOU ARE A CONSERVATEE UNDER THE LANTERMAN-PETRIS-SHORT ACT AND YOU WANT TO APPOINT YOUR CONSERVATOR AS YOUR AGENT. YOU CAN DO THAT ONLY IF THE APPOINTMENT DOCUMENT INCLUDES A CERTIFICATE OF YOUR ATTORNEY.

1. **DESIGNATION OF HEALTH CARE AGENTS.** I,

_____

(Insert your name and address)

do hereby designate and appoint _____

_____

(Insert name, address, and telephone number of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: (1) your treating health care provider, (2) a nonrelative employee of your treating health care provider, (3) an operator of a community care facility, or (4) a nonrelative employee of an operator of a community care facility.)

as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

2. **CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.** By this document I intend to create a durable power of attorney for health care under Sections 2430 to 2443, inclusive, of the California Civil Code. This power of attorney is authorized by the Keene Health Care Agent Act and shall be construed in accordance with the provisions of Sections 2500 to 2506, inclusive, of the California Civil Code. This power of attorney shall not be affected by my subsequent incapacity.

3. **GENERAL STATEMENT OF AUTHORITY GRANTED.** Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") below. You can indicate your desires by including a statement of your desires in the same paragraph.)

4. **STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS.**

(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

(a) Statement of desires concerning life-prolonging care, treatment, services, and procedures:

_____

_____

_____

_____

_____

_____

_____

_____

(b) Additional statement of desires, special provisions, and limitations: _____

_____

_____

_____

_____

_____

_____

_____

_____

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)

5. **INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH.** Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") above.)

6. **SIGNING DOCUMENTS, WAIVERS, AND RELEASES.** Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital or physician.

7. **AUTOPSY; ANATOMICAL GIFTS; DISPOSITION OF REMAINS.** Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Authorize an autopsy under Section 7113 of the Health and Safety Code.

(b) Make a disposition of a part or parts of my body under the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code).

(c) Direct the disposition of my remains under Section 7100 of the Health and Safety Code.

(If you want to limit the authority of your agent to consent to an autopsy, make an anatomical gift, or direct the disposition of your remains, you must state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") above.)

8. **DURATION.**

(Unless you specify a shorter period in the space below, this power of attorney will exist for seven years from the date you execute this document and, if you are unable to make health care decisions for yourself at the time when this seven-year period ends, the power will continue to exist until the time when you become able to make health care decisions for yourself.)

This durable power of attorney for health care expires on _____

_____

(Fill in this space ONLY if you want the authority of your agent to end EARLIER than the seven-year period described above.)

9. **DESIGNATION OF ALTERNATE AGENTS.**

(You 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 health care decisions as the agent you designated in paragraph 1, above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternate Agent _____

_____

(Insert name, address, and telephone number of first alternate agent)

B. Second Alternate Agent _____

_____

(Insert name, address, and telephone number of second alternate agent)

10. **NOMINATION OF CONSERVATOR OF PERSON.**

(A conservator of the person may be appointed for you if a court decides that one should be appointed. The conservator is responsible for your physical care, which under some circumstances includes making health care decisions for you. You are not required to nominate a conservator but you may do so. The court will appoint the person you nominate unless that would

be contrary to your best interests. You may, but are not required to, nominate as your conservator the same person you named in paragraph 1 as your health care agent. You can nominate an individual as your conservator by completing the space below.)

If a conservator of the person is to be appointed for me, I nominate the following individual to serve as conservator of the person

_____

(Insert name and address of person nominated as conservator of the person)

11. **PRIOR DESIGNATIONS REVOKED.** I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on

_____ at _____, _____.

Date *(City)* *(State)*

_____

(You sign here)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.)

STATEMENT OF WITNESSES

(This document must be witnessed by two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as your agent or alternate agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

(READ CAREFULLY BEFORE SIGNING. You can sign as a witness only if you personally know the principal or the identity of the principal is proved to you by convincing evidence.)

(To have convincing evidence of the identity of the principal, you must be presented with and reasonably rely on any one or more of the following:

(1) An identification card or driver's license issued by the California Department of Motor Vehicles that is current or has been issued within five years.

(2) A passport issued by the Department of State of the United States that is current or has been issued within five years.

(3) Any of the following documents if the document is current or has been issued within five years and contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number.

(a) A passport issued by a foreign government that has been stamped by the United States Immigration and Naturalization Service.

(b) A driver's license issued by a state other than California or by a Canadian or Mexican public agency authorized to issue driver's licenses.

(c) An identification card issued by a state other than California.

(d) An identification card issued by any branch of the armed forces of the United States.)

(Other kinds of proof of identity are not allowed.)

I declare under penalty of perjury under the laws of California that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

Signature: _____ Residence Address: _____

Print Name: _____

Date: _____

Signature: _____ Residence Address: _____

Print Name: _____

Date: _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare under penalty of perjury under the laws of California that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

Signature _____

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

(If you are a patient in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman. The following statement is required only if you are a patient in a skilled nursing facility — a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombusdman must sign both parts of the "Statement of Witnesses" above AND must also sign the following statement.)

I further declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by subdivision (f) of Section 2432 of the Civil Code.

Signature: _____

(Added by Stats. 1984, c. 312, § 8. Amended by Stats. 1985, c. 403, p. ——, § 10.)

CALIFORNIA DURABLE POWER OF ATTORNEY
(Immediate Power)
WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

THIS DOCUMENT MAY PROVIDE THE PERSON YOU DESIGNATE AS YOUR ATTORNEY IN FACT WITH BROAD POWERS TO MANAGE, DISPOSE, SELL, AND CONVEY YOUR REAL AND PERSONAL PROPERTY AND TO BORROW MONEY USING YOUR PROPERTY AS SECURITY FOR THE LOAN.

THESE POWERS WILL EXIST FOR AN INDEFINITE PERIOD OF TIME UNLESS YOU LIMIT THEIR DURATION IN THIS DOCUMENT. THESE POWERS WILL CONTINUE TO EXIST NOTWITHSTANDING YOUR SUBSEQUENT DISABILITY OR INCAPACITY.

YOU HAVE THE RIGHT TO REVOKE OR TERMINATE THIS POWER OF ATTORNEY.

IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

Created by _____ as Principal.

1. I, _____
Name of Principal

of _____,
Address *City* *State*

as principal (the "Principal") intend to create by this instrument a Durable Power of Attorney and do hereby appoint

_____ of
Name of Agent

_____
Address *City* *State*

("Agent") to act for me and in my name and exercise the powers set forth below.

2. My Agent is authorized in my Agent's sole and absolute discretion from time to time and at any time, with respect to any and all of my property and interests in property, real, personal, intangible and mixed, as follows:

(a) Real Property Transactions: To lease, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any interest in real property whatsoever, on such terms and conditions, and under such covenants, as my Agent shall deem proper; and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens, mortgage, subject to deeds of trust, and in any way or manner deal with all or any part of any interest in real property whatsoever, that I own at the time of execution or may thereafter acquire, for under such terms and conditions, and under such covenants, as my Agent shall deem proper; and, to supplement this instrument by adding or modifying the descriptions of any property, real or personal, which I may now or hereafter own, in whole or in part.

(b) Personal Property Transactions: To lease, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any personal property whatsoever, tangible or intangible, or interest thereto, on such terms and conditions, and under such covenants, as my Agent shall deem proper, and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens, mortgages, subject to deeds of trust, and hypothecate, and in any way or manner deal with all or any part of any real or personal property whatsoever, tangible or intangible, or any interest therein, that I own at the time or execution or may thereafter acquire, under such terms and conditions, and under such covenants, as my Agent shall deem proper.

(c) Bond, Share and Commodity Transactions: To request, ask, demand, sue for, recover, collect, receive, and hold and possess any bond, share, instrument or similar character, commodity interest or any instrument with respect thereto together with the interest, dividends, proceeds, or other distributions connected therewith, as now are, or shall hereafter become, owned by, or due, owing payable, or belonging to, me at the time of execution or in which I may thereafter acquire interest; to have, use, and take all lawful means and equitable and legal remedies, procedures, and writs in my name for the collection and recovery thereof, and to adjust, sell, compromise, and agree for the same, and to make, execute, and deliver for me, all endorsements, acquittances, releases, receipts, or other sufficient discharges for the same.

(d) Banking Transactions: To make, receive, sign, endorse, execute, acknowledge, deliver, and possess checks, drafts, bills of exchange, letters of credit, notes, stock certificates, withdrawal receipts and deposit instruments relating to accounts or deposits in, or certificates of deposit of, banks, savings and loan or other institutions or associations for me.

(e) Safe Deposits: To have free access at any time to any safe deposit box or vault to which I might have access; and to contract with any institution for the maintenance of a safe deposit box in my name; and to add to and remove from the contents of any such safe deposit box.

(f) Business Operating Transactions: To conduct, engage in, and transact any and all lawful business of whatever nature or kind for me; to continue the operation of any business I own or have an interest in; to sell, liquidate or close out such business at such time and upon such terms as my Agent shall deem appropriate; to represent me and to exercise any right or power I may have in any partnership whether as a general, special or limited partner; to exercise all rights with respect to any securities I may now own or acquire hereafter in any public corporation, including the right to sell, hypothecate, buy the same or different securities and to vote at all meetings of the stockholders.

(g) Insurance Transactions: To exercise or perform any act, power, duty, right or obligation whatsoever in regard to any contract of life, accident, health, disability or liability insurance of any combination of such insurance procured by or on behalf of me prior to execution; and to procure new, different or additional contracts of insurance for me and to designate the beneficiary of any such contract of insurance, provided, however, that the Agent himself cannot be such beneficiary unless the Agent is my spouse, child, grandchild, parent, brother or sister.

(h) Estate Transactions: To request, ask, demand, sue for, recover, collect, receive, and hold and possess all legacies, bequests, devises, as are, owned by, or due, owing, payable, or belonging to, me at the time of execution or in which I may thereafter acquire interest; to have, use, and take all lawful means and equitable and legal remedies, procedures, and writs in my name for the collection and recovery thereof; and to adjust, sell, compromise, and agree for the same, and to make, execute, and deliver for me, all endorsements, acquittances, releases, receipts, or other sufficient discharges for the same.

(i) Personal Relationships and Affairs: To do all acts necessary for maintaining the customary standard of living for me, my spouse and children, and other dependents; to provide medical, dental and surgical care, hospitalization and custodial care for me, my spouse, and children and other dependents; to continue whatever provision has been made by me, for me, my spouse, and children, and other dependents, with respect to automobiles, or other means of transportation; to continue whatever charge accounts have been operated by me, to open such new accounts as my Agent shall think to be desirable for the accomplishment of any of the purposes enumerated in this section, and to pay the items charged on such accounts by any person authorized or permitted by me or my Agent to make such charges; to continue the discharge of any services or duties assumed by me, to any parent, relative or friend of mine; to continue payments incidental to my membership or affiliation in any church, club, society, order or other organization, or to continue contributions thereto.

(j) Tax, Social Security and Unemployment: To prepare, execute and file all tax, social security, unemployment insurance and information returns for tax years between 1970 and 2020 required by the laws of the United States, or of any state or subdivision thereof, or of any foreign government; to prepare, execute and file all other papers and instruments which the Agent shall think to be desirable or necessary to safeguard me against excess or illegal taxation or against penalties imposed for claimed violation of any law or other governmental regulation; and to pay, compromise, contest or apply for refunds in connection with any taxes or assessments for which I am or may be liable.

(k) Benefits from Military Service: To execute vouchers in my name for any and all allowances and reimbursements payable by the United States, or subdivision thereof, to me, arising from or based upon military service and to receive, endorse and collect the proceeds of any check payable to me drawn on the treasurer or other fiscal officer or depository of the United States or subdivision thereof; to take possession and to order the removal and shipment, of any property belonging to me from any post, warehouse, depot, dock or other place of storage or safekeeping, either governmental or private; to execute and to deliver any release, voucher, receipt, bill of lading, shipping ticket, certificate or other instrument which the Agent shall think to be desirable or necessary for such purpose; to prepare, to file and to prosecute my claim to any benefit or assistance, financial or otherwise, to which I am or claim to be, entitled, under the provisions of any statute or regulation existing at the creation of the agency or thereafter enacted by the United States or by any state or by any subdivision thereof, or by any foreign government, which benefit or assistance arises from or is based upon military service performed prior to or after execution.

(l) Revocable Trust: To execute a revocable trust agreement with such trustee as my Agent shall select which trust shall pay to me or disburse on my behalf such amounts of income or principal as necessary for my proper health, support and maintenance, and that on my death any remaining income and principal shall be paid to my personal representative, and that said trust may be revoked or amended by me or my Agent at any time and from time to time, provided that any such amendment by my Agent shall not include any provision which could not be included in the original trust agreement; to deliver and convey any or all of my assets to the trustee thereof; to add any or all of my assets to such a trust already in existence at the time this instrument is executed or at any time thereafter.

3. This power of attorney shall not be affected by subsequent disability or incapacity of the principal.

4. No person who acts in reliance upon any representations made by my Agent as to (a) the continued validity of the Durable Power of Attorney, (b) the scope of powers granted under this instrument, (c) my competency at the time this instrument was executed, or (d) the fact that this instrument has not been revoked, shall incur any liability to me, my estate, my heirs or assigns as a result of any dealings with my Agent, nor shall any person who deals with my Agent shall inquire into the proper application of funds or property.

5. I reserve unto myself the right to amend or revoke this instrument, and to remove my Agent and any alternate agent by executing a written instrument of revocation, amendment, or removal and delivering it to my Agent and to all alternate agents. If the instrument has been recorded in the public records, then the instrument of revocation, amendment or removal shall be filed or recorded in the same public records.

6. If my spouse has been appointed as my Agent herein, and subsequent to the execution of this instrument, legal proceedings are instituted for separation and dissolution of our marriage, institution of such proceedings shall automatically remove my spouse as my Agent.

7. My Agent shall be entitled to reimbursement for all reasonable costs actually incurred and paid by my Agent on my behalf under the authority granted in this instrument.

8. To the extent permitted by law, I herewith nominate, constitute and appoint my Agent to serve as my guardian, conservator and/or in any similar representative capacity; and, if I am not permitted by law to so nominate, constitute and appoint, then I request any court of competent jurisdiction which may be petitioned by any person to appoint a guardian, conservator or similar representative for me to give due consideration to my request.

9. In the event my Agent is unable or unwilling to serve or to continue to serve, then I appoint

_____
Name of Successor Agent

of _____ _____ _____
Address *City* *State*

to serve as substitute or successor agent who shall have all the title, powers and discretion herein given my Agent.

10. My Agent is authorized to make photocopies of this instrument as frequently as necessary. All photocopies shall have the same force and effect as the original.

11. If any provision of this instrument or its application to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this instrument which can be given effect without the invalid provision or application, and to this end the provisions of this instrument are severable.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at _____,

this _____ day of _____, 19_____.

_____
Signature of Principal

_____
Name of Principal

Witnesses

_____ of _____ _____
Signature of Witness *City* *State*

_____ of _____ _____
Signature of Witness *City* *State*

STATE OF _____

COUNTY OF _____

On this _____ day of _____,

_____

in the year _____, before me, the undersigned, a Notary Public in and for said State personally appeared

_____, personally

_____

known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged to me that he/she executed the same. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and official seal.

_____
Notary Public

(Notary Seal)

_____

_____

_____

_____

The undersigned acknowledges and accepts appointment as Agent under this instrument on this _____ day of _____, in the year _____.

_____

Signature of Agent

_____

Name of Agent

CALIFORNIA DURABLE POWER OF ATTORNEY
("Springing" Power)
WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

THIS DOCUMENT MAY PROVIDE THE PERSON YOU DESIGNATE AS YOUR ATTORNEY IN FACT WITH BROAD POWERS TO MANAGE, DISPOSE, SELL, AND CONVEY YOUR REAL AND PERSONAL PROPERTY AND TO BORROW MONEY USING YOUR PROPERTY AS SECURITY FOR THE LOAN.

THESE POWERS WILL EXIST FOR AN INDEFINITE PERIOD OF TIME UNLESS YOU LIMIT THEIR DURATION IN THIS DOCUMENT. THESE POWERS WILL CONTINUE TO EXIST NOTWITHSTANDING YOUR SUBSEQUENT DISABILITY OR INCAPACITY.

YOU HAVE THE RIGHT TO REVOKE OR TERMINATE THIS POWER OF ATTORNEY.

IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

Created by _____ as Principal.

1. I, _____
Name of Principal

of _____,
Address *City* *State*

as principal (the "Principal") intend to create by this instrument a Durable Power of Attorney and do hereby appoint

_____ of
Name of Agent

_____
Address *City* *State*

("Agent") to act for me and in my name and exercise the powers set forth below.

2. My Agent is authorized in my Agent's sole and absolute discretion from time to time and at any time, with respect to any and all of my property and interests in property, real, personal, intangible and mixed, as follows:

(a) Real Property Transactions: To lease, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any interest in real property whatsoever, on such terms and conditions, and under such covenants, as my Agent shall deem proper; and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens, mortgage, subject to deeds of trust, and in any way or manner deal with all or any part of any interest in real property whatsoever, that I own at the time of execution or may thereafter acquire, for under such terms and conditions, and under such covenants, as my Agent shall deem proper; and, to supplement this instrument by adding or modifying the descriptions of any property, real or personal, which I may now or hereafter own, in whole or in part.

(b) Personal Property Transactions: To lease, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any personal property whatsoever, tangible or intangible, or interest thereto, on such terms and conditions, and under such covenants, as my Agent shall deem proper, and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens, mortgages, subject to deeds of trust, and hypothecate, and in any way or manner deal with all or any part of any real or personal property whatsoever, tangible or intangible, or any interest therein, that I own at the time or execution or may thereafter acquire, under such terms and conditions, and under such covenants, as my Agent shall deem proper.

(c) Bond, Share and Commodity Transactions: To request, ask, demand, sue for, recover, collect, receive, and hold and possess any bond, share, instrument or similar character, commodity interest or any instrument with respect thereto together with the interest, dividends, proceeds, or other distributions connected therewith, as now are, or shall hereafter become, owned by, or due, owing payable, or belonging to, me at the time of execution or in which I may thereafter acquire interest; to have, use, and take all lawful means and equitable and legal remedies, procedures, and writs in my name for the collection and recovery thereof, and to adjust, sell, compromise, and agree for the same, and to make, execute, and deliver for me, all endorsements, acquittances, releases, receipts, or other sufficient discharges for the same.

(d) Banking Transactions: To make, receive, sign, endorse, execute, acknowledge, deliver, and possess checks, drafts, bills of exchange, letters of credit, notes, stock certificates, withdrawal receipts and deposit instruments relating to accounts or deposits in, or certificates of deposit of, banks, savings and loan or other institutions or associations for me.

(e) Safe Deposits: To have free access at any time to any safe deposit box or vault to which I might have access; and to contract with any institution for the maintenance of a safe deposit box in my name; and to add to and remove from the contents of any such safe deposit box.

(f) Business Operating Transactions: To conduct, engage in, and transact any and all lawful business of whatever nature or kind for me; to continue the operation of any business I own or have an interest in; to sell, liquidate or close out such business at such time and upon such terms as my Agent shall deem appropriate; to represent me and to exercise any right or power I may have in any partnership whether as a general, special or limited partner; to exercise all rights with respect to any securities I may now own or acquire hereafter in any public corporation, including the right to sell, hypothecate, buy the same or different securities and to vote at all meetings of the stockholders.

(g) Insurance Transactions: To exercise or perform any act, power, duty, right or obligation whatsoever in regard to any contract of life, accident, health, disability or liability insurance of any combination of such insurance procured by or on behalf of me prior to execution; and to procure new, different or additional contracts of insurance for me and to designate the beneficiary of any such contract of insurance, provided, however, that the Agent himself cannot be such beneficiary unless the Agent is my spouse, child, grandchild, parent, brother or sister.

(h) Estate Transactions: To request, ask, demand, sue for, recover, collect, receive, and hold and possess all legacies, bequests, devises, as are, owned by, or due, owing, payable, or belonging to, me at the time of execution or in which I may thereafter acquire interest; to have, use, and take all lawful means and equitable and legal remedies, procedures, and writs in my name for the collection and recovery thereof; and to adjust, sell, compromise, and agree for the same, and to make, execute, and deliver for me, all endorsements, acquittances, releases, receipts, or other sufficient discharges for the same.

(i) Personal Relationships and Affairs: To do all acts necessary for maintaining the customary standard of living for me, my spouse and children, and other dependents; to provide medical, dental and surgical care, hospitalization and custodial care for me, my spouse, and children and other dependents; to continue whatever provision has been made by me, for me, my spouse, and children, and other dependents, with respect to automobiles, or other means of transportation; to continue whatever charge accounts have been operated by me, to open such new accounts as my Agent shall think to be desirable for the accomplishment of any of the purposes enumerated in this section, and to pay the items charged on such accounts by any person authorized or permitted by me or my Agent to make such charges; to continue the discharge of any services or duties assumed by me, to any parent, relative or friend of mine; to continue payments incidental to my membership or affiliation in any church, club, society, order or other organization, or to continue contributions thereto.

(j) Tax, Social Security and Unemployment: To prepare, execute and file all tax, social security, unemployment insurance and information returns for tax years between 1970 and 2020 required by the laws of the United States, or of any state or subdivision thereof, or of any foreign government; to prepare, execute and file all other papers and instruments which the Agent shall think to be desirable or necessary to safeguard me against excess or illegal taxation or against penalties imposed for claimed violation of any law or other governmental regulation; and to pay, compromise, contest or apply for refunds in connection with any taxes or assessments for which I am or may be liable.

(k) Benefits from Military Service: To execute vouchers in my name for any and all allowances and reimbursements payable by the United States, or subdivision thereof, to me, arising from or based upon military service and to receive, endorse and collect the proceeds of any check payable to me drawn on the treasurer or other fiscal officer or depository of the United States or subdivision thereof; to take possession and to order the removal and shipment, of any property belonging to me from any post, warehouse, depot, dock or other place of storage or safekeeping, either governmental or private; to execute and to deliver any release, voucher, receipt, bill of lading, shipping ticket, certificate or other instrument which the Agent shall think to be desirable or necessary for such purpose; to prepare, to file and to prosecute my claim to any benefit or assistance, financial or otherwise, to which I am or claim to be, entitled, under the provisions of any statute or regulation existing at the creation of the agency or thereafter enacted by the United States or by any state or by any subdivision thereof, or by any foreign government, which benefit or assistance arises from or is based upon military service performed prior to or after execution.

(l) Revocable Trust: To execute a revocable trust agreement with such trustee as my Agent shall select which trust shall pay to me or disburse on my behalf such amounts of income or principal as necessary for my proper health, support and maintenance, and that on my death any remaining income and principal shall be paid to my personal representative, and that said trust may be revoked or amended by me or my Agent at any time and from time to time, provided that any such amendment by my Agent shall not include any provision which could not be included in the original trust agreement; to deliver and convey any or all of my assets to the trustee thereof; to add any or all of my assets to such a trust already in existence at the time this instrument is executed or at any time thereafter.

3. This power of attorney shall become effective upon the disability or incapacity of the principal. Notwithstanding any provision herein to the contrary, my Agent shall take no action under this instrument unless I am deemed to be disabled or incapacitated as defined herein. My incapacity shall be deemed to exist when so certified in writing by two licensed physicians not related by blood or marriage to either me or to my Agent. The said certificate shall state that I am incapable of caring for myself and that I am physically and mentally incapable of managing my financial affairs. The certificate of the physicians described above shall be attached to the original of this instrument and if this instrument is filed or recorded among public records, then such certificate shall also be similarly filed or recorded if permitted by applicable law.

4. No person who acts in reliance upon any representations made by my Agent as to (a) the continued validity of the Durable Power of Attorney, (b) the scope of powers granted under this instrument, (c) my competency at the time this instrument was executed, or (d) the fact that this instrument has not been revoked, shall incur any liability to me, my estate, my heirs or assigns as a result of any dealings with my Agent, nor shall any person who deals with my Agent shall inquire into the proper application of funds or property.

5. I reserve unto myself the right to amend or revoke this instrument, and to remove my Agent and any alternate agent by executing a written instrument of revocation, amendment, or removal and delivering it to my Agent and to all alternate agents. If the instrument has been recorded in the public records, then the instrument of revocation, amendment or removal shall be filed or recorded in the same public records.

6. If my spouse has been appointed as my Agent herein, and subsequent to the execution of this instrument, legal proceedings are instituted for separation and dissolution of our marriage, institution of such proceedings shall automatically remove my spouse as my Agent.

7. My Agent shall be entitled to reimbursement for all reasonable costs actually incurred and paid by my Agent on my behalf under the authority granted in this instrument.

8. To the extent permitted by law, I herewith nominate, constitute and appoint my Agent to serve as my guardian, conservator and/or in any similar representative capacity; and, if I am not permitted by law to so nominate, constitute and appoint, then I request any court of competent jurisdiction which may be petitioned by any person to appoint a guardian, conservator or similar representative for me to give due consideration to my request.

9. In the event my Agent is unable or unwilling to serve or to continue to serve, then I appoint

_____
Name of Successor Agent

of _____
Address *City* *State*

to serve as substitute or successor agent who shall have all the title, powers and discretion herein given my Agent.

10. My Agent is authorized to make photocopies of this instrument as frequently as necessary. All photocopies shall have the same force and effect as the original.

11. If any provision of this instrument or its application to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this instrument which can be given effect without the invalid provision or application, and to this end the provisions of this instrument are severable.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at _____,

this _____ day of _____, 19_____.

_____
Signature of Principal

_____
Name of Principal

Witnesses

_____ of _____
Signature of Witness *City* *State*

_____ of _____
Signature of Witness *City* *State*

STATE OF_____

COUNTY OF _____

On this _____ day of _____,

_____

in the year _____, before me, the undersigned, a Notary Public in and for said State personally appeared

_____, personally

_____

known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged to me that he/she executed the same. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and official seal.

_____
Notary Public

(Notary Seal)

The undersigned acknowledges and accepts appointment as Agent under this instrument on this _____ day of _____, in the year _____.

_____

Signature of Agent

_____

Name of Agent

CALIFORNIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE DPA-11

(Immediate Power)

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT (THE ATTORNEY IN FACT) THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. YOUR AGENT MUST ACT CONSISTENTLY WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN.

EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT NECESSARY TO KEEP YOU ALIVE.

NOT WITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT AT THE TIME.

THIS DOCUMENT GIVES YOUR AGENT AUTHORITY TO CONSENT, TO REFUSE TO CONSENT, OR TO WITHDRAW CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. THIS POWER IS SUBJECT TO ANY STATEMENT OF YOUR DESIRES AND ANY LIMITATIONS THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT THAT YOU DO NOT DESIRE. IN ADDITION, A COURT CAN TAKE AWAY THE POWER OF YOUR AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOUR AGENT (1) AUTHORIZES ANYTHING THAT IS ILLEGAL, (2) ACTS CONTRARY TO YOUR KNOWN DESIRES, OR (3) WHERE YOUR DESIRES ARE NOT KNOWN, DOES ANYTHING THAT IS CLEARLY CONTRARY TO YOUR BEST INTERESTS.

UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST FOR SEVEN YEARS FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF AT THE TIME WHEN THIS SEVEN-YEAR PERIOD ENDS, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY OF YOUR AGENT BY NOTIFYING YOUR AGENT OR YOUR TREATING DOCTOR, HOSPITAL, OR OTHER HEALTH CARE PROVIDER ORALLY OR IN WRITING OF THE REVOCATION.

YOUR AGENT HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

UNLESS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER AFTER YOU DIE TO (1) AUTHORIZE AN AUTOPSY, (2) DONATE YOUR BODY OR PARTS THEREOF FOR TRANSPLANT OR THERAPEUTIC OR EDUCATIONAL OR SCIENTIFIC PURPOSES, AND (3) DIRECT THE DISPOSITION OF YOUR REMAINS.

IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

"THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY TWO QUALIFIED ADULT WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC IN CALIFORNIA."

Created by _____ as Principal.

1. I, _____
Name of Principal

of _____,
Address *City* *State*

as principal (the "Principal") intend to create by this instrument a Durable Power of Attorney for health care and do hereby appoint

_____ of
Name of Agent

_____
Address *City* *State*

my Agent ("Agent") to act for me and in my name and exercise the powers set forth below in matters involving my health and medical care. Accordingly, my Agent is authorized as follows:

2. Subject to any limitations in this document, I hereby grant to my Agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my Agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my Agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

3. I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of health care, including hospitals, to release to my Agent all information contained in my medical records which my Agent may request. I hereby waive all privileges attached to physician-patient relationship and to any communication, verbal or written, arising out of such a relationship. My Agent is authorized to request, receive and review any information, verbal or written, pertaining to my physical or mental health, including medical and hospital records, and to execute any releases, waivers or other documents that may be required in order to obtain such information, and to disclose such information to such persons, organizations and health care providers as my Agent shall deem appropriate.

4. My Agent is authorized to employ and discharge health care providers including physicians, psychiatrists, dentists, nurses, and therapists as my Agent shall deem appropriate for my physical, mental and emotional well-being. My Agent is also authorized to pay reasonable fees and expenses for such services contracted.

5. My Agent is authorized to apply for my admission to a medical, nursing, residential or other similar facility, execute any consent or admission forms required by such facility and enter into agreements for my care at such facility or elsewhere during my lifetime or for such lesser periods of time as my Agent may designate.

6. My Agent is authorized to arrange for and consent to medical, therapeutical and surgical procedures for me including the administration of drugs. The power to make health care decisions for me shall include the power to give consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

7. I reserve unto myself the right to revoke the authority granted to my Agent hereunder to make health care decisions for me by notifying the treating physician, hospital, or other health care provider orally or in writing.

8. Notwithstanding any provision herein to the contrary, I retain the right to make medical and other health care decisions for myself so long as I am able to give informed consent with respect to a particular decision. In addition, no treatment may be given to me over my objection, and health care necessary to keep me alive may not be stopped if I object.

9. If at any time I should have a terminal condition and my attending physician and another physician, independently of each other, have determined that there can be no recovery from such condition and my death is imminent, where the application of life-prolonging procedures would serve only to artificially prolong 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 or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

For purposes of this declaration, life-prolonging procedure shall mean any medical procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process. "Life-prolonging procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

10. If I have been in an irreversible coma with no reasonable possibility of my ever regaining consciousness, I direct that all procedures used to provide me with nourishment and water (including, for instance, through intravenous feeding and through endotracheal or nasogastric tube means) not be instituted or, if already instituted, withdrawn.

11. This power of attorney shall not be affected by subsequent disability or incapacity of the principal.

12. My Agent shall be entitled to reimbursement for all reasonable costs actually incurred and paid by my Agent on my behalf under the authority granted in this instrument.

13. To the extent permitted by law, I herewith nominate, constitute and appoint my Agent to serve as my guardian, conservator and/or in any similar representative capacity; and, if I am not permitted by law to so nominate, constitute and appoint, then I request any court of competent jurisdiction which may be petitioned by any person to appoint a guardian, conservator or similar representative for me to give due consideration to my request.

14. In the event my Agent is unable or unwilling to serve or to continue to serve, then I appoint

_____

Name of Successor Agent

of _____

Address *City* *State*

to serve as substitute or successor agent who shall have all the title, powers and discretion herein given my Agent.

15. My Agent is authorized to make photocopies of this instrument as frequently as necessary. All photocopies shall have the same force and effect as the original.

16. If any provision of this instrument or its application to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this instrument which can be given effect without the invalid provision or application, and to this end the provisions of this instrument are severable.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at _____,

this _____ day of _____, 19_____.

_____

Signature of Principal

_____

Name of Principal

Witnesses

_____ of _____

Signature of Witness *City* *State*

_____ of _____

Signature of Witness *City* *State*

STATE OF _____

COUNTY OF _____

On this _____ day of _____,

_____

in the year _____, before me, the undersigned, a Notary Public in and for said State personally appeared

_____, personally

known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged to me that he/she executed the same. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and official seal.

_____

Notary Public

(Notary Seal)

_____

_____

The undersigned acknowledges and accepts appointment as Agent under this instrument on this _____

day of _____, in the year _____.

_____

Signature of Agent

_____

Name of Agent

CALIFORNIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

DPA-12

("Springing" Power)

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR AGENT (THE ATTORNEY IN FACT) THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. YOUR AGENT MUST ACT CONSISTENTLY WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN.

EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT NECESSARY TO KEEP YOU ALIVE.

NOT WITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT AT THE TIME.

THIS DOCUMENT GIVES YOUR AGENT AUTHORITY TO CONSENT, TO REFUSE TO CONSENT, OR TO WITHDRAW CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. THIS POWER IS SUBJECT TO ANY STATEMENT OF YOUR DESIRES AND ANY LIMITATIONS THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT THAT YOU DO NOT DESIRE. IN ADDITION, A COURT CAN TAKE AWAY THE POWER OF YOUR AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOUR AGENT (1) AUTHORIZES ANYTHING THAT IS ILLEGAL, (2) ACTS CONTRARY TO YOUR KNOWN DESIRES, OR (3) WHERE YOUR DESIRES ARE NOT KNOWN, DOES ANYTHING THAT IS CLEARLY CONTRARY TO YOUR BEST INTERESTS.

UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST FOR SEVEN YEARS FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF AT THE TIME WHEN THIS SEVEN-YEAR PERIOD ENDS, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY OF YOUR AGENT BY NOTIFYING YOUR AGENT OR YOUR TREATING DOCTOR, HOSPITAL, OR OTHER HEALTH CARE PROVIDER ORALLY OR IN WRITING OF THE REVOCATION.

YOUR AGENT HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

UNLESS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER AFTER YOU DIE TO (1) AUTHORIZE AN AUTOPSY, (2) DONATE YOUR BODY OR PARTS THEREOF FOR TRANSPLANT OR THERAPEUTIC OR EDUCATIONAL OR SCIENTIFIC PURPOSES, AND (3) DIRECT THE DISPOSITION OF YOUR REMAINS.

IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

"THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY TWO QUALIFIED ADULT WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC IN CALIFORNIA."

Created by _____ as Principal.

1. I, _____
Name of Principal

of _____,
Address *City* *State*

as principal (the "Principal") intend to create by this instrument a Durable Power of Attorney for health care and do hereby appoint

_____ of
Name of Agent

_____
Address *City* *State*

my Agent ("Agent") to act for me and in my name and exercise the powers set forth below in matters involving my health and medical care. Accordingly, my Agent is authorized as follows:

2. Subject to any limitations in this document, I hereby grant to my Agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my Agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my Agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

3. I hereby authorize all physicians and psychiatrists who have treated me, and all other providers of health care, including hospitals, to release to my Agent all information contained in my medical records which my Agent may request. I hereby waive all privileges attached to physician-patient relationship and to any communication, verbal or written, arising out of such a relationship. My Agent is authorized to request, receive and review any information, verbal or written, pertaining to my physical or mental health, including medical and hospital records, and to execute any releases, waivers or other documents that may be required in order to obtain such information, and to disclose such information to such persons, organizations and health care providers as my Agent shall deem appropriate.

4. My Agent is authorized to employ and discharge health care providers including physicians, psychiatrists, dentists, nurses, and therapists as my Agent shall deem appropriate for my physical, mental and emotional well-being. My Agent is also authorized to pay reasonable fees and expenses for such services contracted.

5. My Agent is authorized to apply for my admission to a medical, nursing, residential or other similar facility, execute any consent or admission forms required by such facility and enter into agreements for my care at such facility or elsewhere during my lifetime or for such lesser periods of time as my Agent may designate.

6. My Agent is authorized to arrange for and consent to medical, therapeutical and surgical procedures for me including the administration of drugs. The power to make health care decisions for me shall include the power to give consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

7. I reserve unto myself the right to revoke the authority granted to my Agent hereunder to make health care decisions for me by notifying the treating physician, hospital, or other health care provider orally or in writing.

8. Notwithstanding any provision herein to the contrary, I retain the right to make medical and other health care decisions for myself so long as I am able to give informed consent with respect to a particular decision. In addition, no treatment may be given to me over my objection, and health care necessary to keep me alive may not be stopped if I object.

9. If at any time I should have a terminal condition and my attending physician and another physician, independently of each other, have determined that there can be no recovery from such condition and my death is imminent, where the application of life-prolonging procedures would serve only to artificially prolong 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 or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

For purposes of this declaration, life-prolonging procedure shall mean any medical procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process. "Life-prolonging procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.

10. If I have been in an irreversible coma with no reasonable possibility of my ever regaining consciousness, I direct that all procedures used to provide me with nourishment and water (including, for instance, through intravenous feeding and through endotracheal or nasogastric tube means) not be instituted or, if already instituted, withdrawn.

11. This power of attorney shall become effective upon the disability or incapacity of the principal. Notwithstanding any provision herein to the contrary, my Agent shall take no action under this instrument unless I am deemed to be disabled or incapacitated as defined herein. My incapacity shall be deemed to exist when so certified in writing by two licensed physicians not related by blood or marriage to either me or to my Agent. The said certificate shall state that I am incapable of caring

12. My Agent shall be entitled to reimbursement for all reasonable costs actually incurred and paid by my Agent on my behalf under the authority granted in this instrument.

13. To the extent permitted by law, I herewith nominate, constitute and appoint my Agent to serve as my guardian, conservator and/or in any similar representative capacity; and, if I am not permitted by law to so nominate, constitute and appoint, then I request any court of competent jurisdiction which may be petitioned by any person to appoint a guardian, conservator or similar representative for me to give due consideration to my request.

14. In the event my Agent is unable or unwilling to serve or to continue to serve, then I appoint

_____

Name of Successor Agent

of _____

Address *City* *State*

to serve as substitute or successor agent who shall have all the title, powers and discretion herein given my Agent.

15. My Agent is authorized to make photocopies of this instrument as frequently as necessary. All photocopies shall have the same force and effect as the original.

16. If any provision of this instrument or its application to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this instrument which can be given effect without the invalid provision or application, and to this end the provisions of this instrument are severable.

IN WITNESS WHEREOF, I have hereunto set my hand and seal at _____,

this _____ day of _____, 19_____.

_____
Signature of Principal

_____
Name of Principal

Witnesses

_____ of _____
Signature of Witness *City* *State*

_____ of _____
Signature of Witness *City* *State*

STATE OF_____

COUNTY OF _____

On this _____ day of _____,

_____

in the year _____, before me, the undersigned, a Notary Public in and for said State personally appeared

_____, personally

known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged to me that he/she executed the same. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and official seal.

_____
Notary Public

(Notary Seal)

_____

_____

The undersigned acknowledges and accepts appointment as Agent under this instrument on this _____

day of _____, in the year _____.

_____
Signature of Agent

_____
Name of Agent

Connecticut Statutory Short Form Power Of Attorney

DPA-13

"NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE DEFINED IN CONNECTICUT STATUTORY SHORT FORM POWER OF ATTORNEY ACT, SECTIONS 1-42 TO 1-56, AND SECTIONS 45-69O, INCLUSIVE, OF THE GENERAL STATUTES, WHICH EXPRESSLY PERMITS THE USE OF ANY OTHER OR DIFFERENT FORM OF POWER OF ATTORNEY DESIRED BY THE PARTIES CONCERNED.

Know All Men by These Presents, which are intended to constitute a GENERAL POWER OF ATTORNEY pursuant to Connecticut Statutory Short Form Power of Attorney Act:

That I _____ do

(insert name and address of the principal)

hereby appoint _____

(insert name and address of the agent, or

_____

each agent, if more than one is designated)

my attorney(s)-in-fact TO ACT _____

_____

If more than one agent is designated and the principal wishes each agent alone to be able to exercise the power conferred, insert in this blank the word 'severally.' Failure to make any insertion or the insertion of the word 'jointly' shall require the agents to act jointly.

First: In my name, place and stead in any way which I myself could do, if I were personally present, with respect to the following matters as each of them is defined in the Connecticut Statutory Short Form Power of Attorney Act to the extent that I am permitted by law to act through an agent:

(Strike out and initial in the opposite box any one or more of the subdivisions as to which the principal does NOT desire to give the agent authority. Such elimination of any one or more of subdivisions (A) to (K), inclusive, shall automatically constitute an elimination also of subdivision (L).)

To strike out any subdivision the principal must draw a line through the text of the subdivision AND write his initials in the box opposite.

(A) real estate transactions;	( )
(B) chattel and goods transactions;	( )
(C) bond, share and commodity transactions;	( )
(D) banking transactions;	( )
(E) business operating transactions;	( )
(F) insurance transactions;	( )
(G) estate transactions;	( )
(H) claims and litigation;	( )
(I) personal relationships and affairs;	( )
(J) benefits from military service;	( )
(K) records, reports and statements;	( )
(L) all other matters;	( )

_____

_____

_____

_____

(Special provisions and limitations may be included in the statutory short form power of attorney only if they conform to the requirements of the Connecticut Statutory Short Form Power of Attorney Act.)

Second: With full and unqualified authority to delegate any or all of the foregoing powers to any person or persons whom my attorney(s)-in-fact shall select;

Third: Hereby ratifying and confirming all that said attorney(s) or substitute(s) do or cause to be done.

This power of attorney shall not be affected by subsequent disability or incapacity of the principal.

In Witness Whereof I have hereunto signed my name and affixed my seal this _____ day of _____ 19_____.

_____

_____ (Seal)

(Signature of Principal)

STATE OF CONNECTICUT

COUNTY OF _____

On this _____ day of _____,

in the year _____, before me, the undersigned, a Notary Public in and for said State personally appeared

_____, personally

known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged to me that he/she executed the same. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and official seal.

_____

Notary Public

(Notary Seal)

DPA-14

NEW YORK STATUTORY SHORT FORM POWER OF ATTORNEY

"NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE DEFINED IN NEW YORK GENERAL OBLIGATIONS LAW, ARTICLE 5, TITLE 15, SECTIONS 5-1502A THROUGH 5-1503, WHICH EXPRESSLY PERMITS THE USE OF ANY OTHER OR DIFFERENT FORM OF POWER OF ATTORNEY DESIRED BY THE PARTIES CONCERNED."

Know All Men by These Presents, which are intended to constitute a GENERAL POWER OF ATTORNEY pursuant to Article 5, Title 15 of the New York General Obligations Law:

That I _____ do hereby
(insert name and address of the principal)

appoint _____
(insert name and address of the agent, or each agent, if more than one is designated)

my attorney(s)-in-fact TO ACT _____

_____

(a) If more than one agent is designated and the principal wishes each agent alone to be able to exercise the power conferred, insert in this blank the word "severally." Failure to make any insertion or the insertion of the word "jointly" will require the agents to act jointly.

In my name, place and stead in any way which I myself could do, if I were personally present, with respect to the following matters as each of them is defined in Title 15 of Article 5 of the New York General Obligations Law to the extent that I am permitted by law to act through an agent:

(Strike out and initial in the opposite box any one or more of the subdivisions as to which the principal does NOT desire to give the agent authority. Such elimination of any one or more of subdivisions (A) to (L), inclusive, shall automatically constitute an elimination also of subdivision (M).)

To strike out any subdivision the principal must draw a line through the text of that subdivision AND write his initials in the box opposite.

(A) real estate transactions;	( )
(B) chattel and goods transactions;	( )
(C) bond, share and commodity transactions;	( )
(D) banking transactions;	( )
(E) business operating transactions;	( )
(F) insurance transactions;	( )
(G) estate transactions;	( )
(H) claims and litigation;	( )
(I) personal relationships and affairs;	( )
(J) benefits from military service;	( )
(K) records, reports and statements;	( )
(L) full and unqualified authority to my attorney(s)-in-fact to delegate any or all of the foregoing powers to any person or persons whom my attorney(s)-in-fact should select;	( )
(M) all other matters;	

_____

_____

_____

_____

(Special provisions and limitations may be included in the statutory short form power of attorney only if they conform to the requirements of section 5-1503 of the New York General Obligations Law.)

This power of attorney shall not be affected by the subsequent disability or incompetence of the principal.

In Witness Whereof I have hereunto signed my name and affixed my seal this _____ day of _____, 19____.

_____ (Seal)
(Signature of Principal)

STATE OF NEW YORK

COUNTY OF _____

On this _____ day of _____,

in the year _____, before me, the undersigned, a Notary Public in and

for said State personally appeared _____, personally

known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged to me that he/she executed the same. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and official seal.

_____

Notary Public

(Notary Seal)

Chapter 12
How to Revoke a Durable Power of Attorney

In framing a Durable Power of Attorney, you, as a principal, reserve to yourself the authority to revoke or amend the power at any time. You also retain express authority to remove the attorney-in-fact.

By law, you can exercise this authority only so long as you're competent. In the unlikely event that an agent contests his or her removal by a principal whose competency is in doubt, court proceedings would be necessary to establish the capacity of the principal. The standard used to determine the competency is that the principal is of "sound mind" and is acting under no duress or threat.

Prevent Abuse of Power

Of course, when you revoke or amend your Durable Power of Attorney, you should collect all copies of the previous power and destroy them. If you're removing your attorney-in-fact and appointing a different one, you should contact all third parties — such as banks, insurance companies, brokers, physicians, etc. — and let them know that the previous attorney-in-fact no longer represents you. This is of vital importance because the third parties may continue to rely in good faith upon the apparent authority of the attorney-in-fact, even though you've revoked the power. They will be justified in their reliance as long as they have not had actual notice of your revocation.

Automatic Removal of Spouse Upon Separation

Since the Durable Power of Attorney grants the Agent sweeping powers over the person and property of the principal, it's necessary to build safeguards in the power to prevent any possible abuse by a separated or divorced spouse. Thus, if the principal's spouse has been appointed as an agent, and the parties become legally separated or divorced, the power stipulates that the spouse is automatically removed as agent.

Formalities of Revocation

There are a few important formalities that must be observed in connection with the revocation of your Durable Power of Attorney.

- Revocation of power has to be in writing, just as the original instrument that granted the authority.
- The notice of revocation must be delivered to the attorney-in-fact. Prudence dictates that all third persons who may have had dealings with the attorney-in-fact in the past should also be notified.
- The instrument of revocation must be executed in the same manner as the Durable Power of Attorney. For example, your signature must be acknowledged by a Notary Public. Some states require that the instrument be signed in the presence of witnesses.
- If the Durable Power of Attorney was recorded in the city or county records, the notice of revocation must also be recorded in likewise manner. In order for it to be recorded, the instrument has to have been notarized. This would be the case in all real property transactions.

How long is your Durable Power of Attorney valid?

Although most states do not impose any specific time limits upon a Durable Power of Attorney, as a matter of practice, many banks, title insurance companies and other third parties may be reluctant to deal with an agent whose power appears to be "stale." This would especially be true if the power authorizes the agent to make health care decisions for the principal.

A few states, by law, restrict the effectiveness of the power to a prescribed number of years. If the principal has become incompetent during this period, the power will continue to be effective until he regains capacity to manage his own affairs. For example, California Durable Power of Attorney for health care exists for seven years from the date of execution. If you have executed a Living Will, many states require that you re-execute it every five years. Some states require that a Living Will, in order to be valid, must have been executed only after a medical diagnosis of terminal illness has been rendered.

Conclusion

Do not let your Durable Power of Attorney get "stale" or old. You should periodically review your Durable Power of Attorney and reevaluate your relationship with the attorney-in-fact. Circumstances and relationships change over time, and it's prudent to make necessary changes.

A form for Notice of Revocation of Durable Power of Attorney is included here for your use.

DPA-R

Notice of Revocation of Durable Power of Attorney

WHEREAS, I _____,
Name

of _____,
Address

_____,
City *State*

created a Durable Power of Attorney by a written instrument dated _____;

WHEREAS, I, as principal, appointed

_____,
Name of Agent

of _____,
Address *City* *State*

to serve as my Agent and to exercise the powers set forth in the said instrument;

WHEREAS, pursuant to the terms of the said instrument, I reserved unto myself the exclusive right to amend or revoke at any time the powers created thereunder, including the power to remove my Agent, without the consent of my Agent;

NOW THEREFORE, pursuant to the aforesaid right of revocation, I do hereby revoke in its entirety the said Durable Power of Attorney created by me.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this _____

day of _____, 19_____.

_____
Signature of Principal

_____
Name of Principal

STATE OF _____

COUNTY OF _____

On this _____ day of _____,

in the year _____, before me, the undersigned, a Notary Public in and for said State

personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument and acknowledged to me that he/she executed the same. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

Witness my hand and official seal.

_____

Notary Public

(Notary Seal)

APPENDIX

Durable Power of Attorney for Health Care

State Supplements

Alaska Statutes § 13.26.332

General Provisions:

A general power of attorney in the State of Alaska must be substantially in the form provided. This form may be used for health care services, see section (L), but the attorney-in-fact is not authorized to direct the withholding or withdrawal of life support systems.

FORM

GENERAL FORM POWER OF ATTORNEY

THE POWERS GRANTED FROM THE PRINCIPAL TO THE AGENT OR AGENTS IN THE FOLLOWING DOCUMENT ARE VERY BROAD. THEY MAY INCLUDE THE POWER TO DISPOSE, SELL, CONVEY, AND ENCUMBER YOUR REAL AND PERSONAL PROPERTY AND THE POWER TO MAKE YOUR HEALTH CARE DECISIONS. ACCORDINGLY, THE FOLLOWING DOCUMENT SHOULD ONLY BE USED AFTER CAREFUL CONSIDERATION. IF YOU HAVE ANY QUESTIONS ABOUT THIS DOCUMENT, YOU SHOULD SEEK COMPETENT ADVICE.

YOU MAY REVOKE THIS POWER OF ATTORNEY AT ANY TIME.

Pursuant to AS 13.26.338—13.26.353,I, _____ (Name of principal), of _____ (Address of principal), do hereby appoint _____ (Name and address of agent or agents), my attorney(s)-in-fact to act as I have checked below in my name, place, and stead in any way which I myself could do, if I were personally present, with respect to the following matters, as each of them is defined in AS 13.26.344, to the full extent that I am permitted by law to act through an agent:

THE AGENT OR AGENTS YOU HAVE APPOINTED WILL HAVE ALL THE POWERS LISTED BELOW UNLESS YOU DRAW A LINE THROUGH A CATEGORY; AND INITIAL THE BOX OPPOSITE THAT CATEGORY

(A) real estate transactions ( )

(B) transactions involving tangible personal property, chattels, and goods ( )

(C) bonds, shares, and commodities transactions ( )

(D) banking transactions ( )

(E) business operating transactions ( )

(F) insurance transactions ( )

(G) estate transactions ( )

(H) gift transactions ( )
(I) claims and litigation ( )
(J) personal relationships and affairs ( )
(K) benefits from government programs and military service ( )
(L) health care services ( )
(M) records, reports, and statements ( )
(N) delegation ( )
(O) all other matters, including those specified as follows: ( )

_____

_____

_____

IF YOU HAVE APPOINTED MORE THAN ONE AGENT, CHECK ONE OF THE FOLLOWING:

( ) Each agent may exercise the powers conferred separately, without the consent of any other agent.

( ) All agents shall exercise the powers conferred jointly, with the consent of all other agents.

TO INDICATE WHEN THIS DOCUMENT SHALL BECOME EFFECTIVE, CHECK ONE OF THE FOLLOWING:

( ) This document shall become effective upon the date of my signature.

( ) This document shall become effective upon the date of my disability and shall not otherwise be affected by my disability.

IF YOU HAVE INDICATED THAT THIS DOCUMENT SHALL BECOME EFFECTIVE ON THE DATE OF YOUR SIGNATURE, CHECK ONE OF THE FOLLOWING:

( ) This document shall not be affected by my subsequent disability.

( ) This document shall be revoked by my subsequent disability.

IF YOU HAVE INDICATED THAT THIS DOCUMENT SHALL BECOME EFFECTIVE UPON THE DATE OF YOUR SIGNATURE AND WANT TO LIMIT THE TERM OF THIS DOCUMENT, COMPLETE THE FOLLOWING:

This document shall only continue in effect for _____ (_____) years from the date of my signature.

NOTICE OF REVOCATION OF THE POWERS GRANTED IN THIS DOCUMENT

You may revoke one or more of the powers granted in this document. Unless otherwise provided in this document, you may revoke a specific power granted in this power of attorney by completing a special power of attorney that includes the specific power in this document that you want to revoke. Unless otherwise provided in this document, you may revoke all the powers granted in this power of attorney by completing a subsequent power of attorney.

NOTICE TO THIRD PARTIES

A third party who relies on the reasonable representations of an attorney-in-fact as to a matter relating to a power granted by a properly executed statutory power of attorney does not incur any liability to the principal or to the principal's heirs, assigns, or estate as a result of permitting the attorney-in-fact to exercise the authority granted by the power of attorney. A third party who fails to honor a properly executed statutory form power of attorney may be liable to the principal, the attorney-in-fact, the principal's heirs, assigns, or estate for a civil penalty, plus damages, costs, and fees associated with the failure to comply with the statutory form power of attorney. If the power of attorney is one which becomes effective upon the disability of the principal, the disability of the principal is established by an affidavit, as required by law.

IN WITNESS WHEREOF, I have hereunto signed my name this ____ day of _____, ____.

_____

Signature of Principal

Subscribed and sworn to or affirmed before me at _____ on _____.

_____

Signature of Officer or Notary

§ 13.26.335

(1) IF YOU HAVE GIVEN THE AGENT AUTHORITY REGARDING HEALTH CARE SERVICES UNDER SUBDIVISION (L), COMPLETE THE FOLLOWING:

( ) I have executed a separate declaration under AS 18.12, known as a "Living Will."

( ) I have not executed a "Living Will."

(2) YOU MAY DESIGNATE AN ALTERNATE ATTORNEY-IN-FACT. ANY ALTERNATE YOU DESIGNATE WILL BE ABLE TO EXERCISE THE SAME POWERS AS THE AGENT(S) YOU NAMED AT THE BEGINNING OF THIS DOCUMENT. IF YOU WISH TO DESIGNATE AN ALTERNATE OR ALTERNATES, COMPLETE THE FOLLOWING:

If the agent(s) named at the beginning of this document is unable or unwilling to serve or continue to serve, then I appoint the following agent to serve with the same powers:

First alternate or successor attorney-in-fact
(Name and address of alternate)

_____

Second alternate or successor attorney-in-fact
(Name and address of alternate)

_____

(3) YOU MAY NOMINATE A GUARDIAN OR CONSERVATOR. IF YOU WISH TO NOMINATE A GUARDIAN OR CONSERVATOR, COMPLETE THE FOLLOWING:

In the event that a court decides that it is necessary to appoint a guardian or conservator for me, I hereby nominate _____ (Name and address of person nominated) to be considered by the court for appointment to serve as my guardian or conservator, or in any similar representative capacity. (§ 1 ch 109 SLA 1988)

California Civil Code § 2500

General Provisions:

A durable power of attorney for health care in the State of California should be in the form provided. The principal must sign the durable power of attorney him or herself and it must be witnessed by two qualified adult witnesses.

None of the following may be used as a witness: (1) a person designated as the agent or alternative agent; (2) a health care provider; (3) an employee of a health care provider; (4) the operator of a community care facility; (5) an employee of an operator of a community care facility; (6) the operator of a residential care facility for the elderly; or (7) an employee of an operator of a residential care facility for the elderly. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.

The witnesses can only sign if they personally know the principal or the identity of the principal is proved by convincing evidence. To have convincing evidence of the identity of the principal, the witnesses must be presented with and reasonably rely on any one or more of the following:

(1) An identification card or driver's license issued by the California Department of Motor Vehicles that is current or has been issued within five years.

(2) A passport issued by the Department of State of the United States that is current or has been issued within the past five years.

(3) Any of the following documents if the document is current or has been issued within the past five years and contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number:

(a) A passport issued by a foreign government that has been stamped by the United Sates Immigration and Naturalization Service.

(b) A driver's license issued by a state other than California or by a Canadian or Mexican public agency authorized to issue driver's licenses.

(c) An identification card issued by a state other than California.

(d) An identification card issued by any branch of the armed forces of the United States.

FORM

STATUTORY FORM DURABLE POWER OF ATTORNEY FOR HEALTH CARE (California Civil Code Section 2500) WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT WHICH IS AUTHORIZED BY THE KEENE HEALTH CARE AGENT ACT. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS

YOUR AGENT (THE ATTORNEY IN FACT) THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. YOUR AGENT MUST ACT CONSISTENTLY WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN.

EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT NECESSARY TO KEEP YOU ALIVE.

NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION AT THE TIME, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT AT THE TIME.

THIS DOCUMENT GIVES YOUR AGENT AUTHORITY TO CONSENT, TO REFUSE TO CONSENT, OR TO WITHDRAW CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. THIS POWER IS SUBJECT TO ANY STATEMENT OF YOUR DESIRES AND ANY LIMITATIONS THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT THAT YOU DO NOT DESIRE. IN ADDITION, A COURT CAN TAKE AWAY THE POWER OF YOUR AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOUR AGENT (1) AUTHORIZES ANYTHING THAT IS ILLEGAL, (2) ACTS CONTRARY TO YOUR KNOWN DESIRES, OR (3) WHERE YOUR DESIRES ARE NOT KNOWN, DOES ANYTHING THAT IS CLEARLY CONTRARY TO YOUR BEST INTERESTS.

THE POWERS GIVEN BY THIS DOCUMENT WILL EXIST FOR AN INDEFINITE PERIOD OF TIME UNLESS YOU LIMIT THEIR DURATION IN THIS DOCUMENT.

YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY OF YOUR AGENT BY NOTIFYING YOUR AGENT OR YOUR TREATING DOCTOR, HOSPITAL, OR OTHER HEALTH CARE PROVIDER ORALLY OR IN WRITING OF THE REVOCATION.

YOUR AGENT HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

UNLESS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THIS DOCUMENT GIVES YOUR AGENT THE POWER AFTER YOU DIE TO (1) AUTHORIZE AN AUTOPSY, (2) DONATE YOUR BODY OR PARTS THEREOF FOR TRANSPLANT OR THERAPEUTIC OR EDUCATIONAL OR SCIENTIFIC PURPOSES, AND (3) DIRECT THE DISPOSITION OF YOUR REMAINS.

THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

YOU SHOULD CAREFULLY READ AND FOLLOW THE WITNESSING PROCEDURE DESCRIBED AT THE END OF THIS FORM. THIS DOCUMENT WILL NOT BE VALID UNLESS YOU COMPLY WITH THE WITNESSING PROCEDURE.

IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

YOUR AGENT MAY NEED THIS DOCUMENT IMMEDIATELY IN CASE OF AN EMERGENCY THAT REQUIRES A DECISION CONCERNING YOUR HEALTH CARE. EITHER KEEP THIS DOCUMENT WHERE IT IS IMMEDIATELY AVAILABLE TO YOUR AGENT AND ALTERNATE AGENTS OR GIVE EACH OF THEM AN EXECUTED COPY OF THIS DOCUMENT. YOU MAY ALSO WANT TO GIVE YOUR DOCTOR AN EXECUTED COPY OF THIS DOCUMENT.

DO NOT USE THIS FORM IF YOU ARE A CONSERVATEE UNDER THE LANTERMAN-PETRIS-SHORT ACT AND YOU WANT TO APPOINT YOUR CONSERVATOR AS YOU AGENT. YOU CAN DO THAT ONLY IF THE APPOINTMENT DOCUMENT INCLUDES A CERTIFICATE OF YOUR ATTORNEY.

1. DESIGNATION OF HEALTH CARE AGENT. I,

_____

(Insert your name and address)

do hereby designate and appoint_____

_____

(Insert name, address, and telephone number of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: (1) your treating health care provider, (2) a nonrelative employee of your treating health care provider, (3) an operator of a community care facility, (4) a nonrelative employee of an operator of a community care facility, (5) an operator of a residential care facility for the elderly; or (6) a nonrelative employee of an operator of a residential care facility for the elderly.)

as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney for health care under Sections 2430 to 2443, inclusive, of the California Civil Code. This power of attorney is authorized by the Keene Health Care Agent Act and shall be construed in accordance with the provisions of Sections 2500 to 2506, inclusive, of the California Civil Code. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to

any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures. (If you want to limit the authority of you agent to make health care decisions for you, you can state the limitations in paragraph 4 (Statement of Desires, Special Provisions, and Limitations") below. You can indicate your desires by including a statement of your desires in the same paragraph.)

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. (Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

(a) Statement of desires concerning life-prolonging care, treatment, services, and procedures:

_____

_____

_____

_____

_____

_____

_____

_____

(b) Additional statement of desires, special provisions, and limitations:_____

_____

_____

_____

_____

_____

_____

_____

_____

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information. (If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") above.)

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital or physician.

7. AUTOPSY; ANATOMICAL GIFTS; DISPOSITION OF REMAINS. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

(a) Authorize an autopsy under Section 7113 of the Health and Safety Code.

(b) Make a disposition of a part or parts of my body under the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code).

(c) Direct the disposition of my remains under Section 7100 of the Health and Safety Code. (If you want to limit the authority of your agent to consent to an autopsy, make an anatomical gift, or direct the disposition of your remains, you must state the limitations in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") above.)

8. DURATION. (Unless you specify otherwise in the space below, this power of attorney will exist for an indefinite period of time.)

This durable power of attorney for health care expires on

_____

_____

(Fill in this space ONLY if you want to limit the duration of this power of attorney.)

9. DESIGNATION OF ALTERNATE AGENTS. (You 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 health care decisions as the agent you designated in paragraph 1, above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternate Agent_____

_____

(Insert name, address, and telephone number of first alternate agent)

B. Second Alternate Agent_____

_____

(Insert name, address, and telephone number of second alternate agent)

10. NOMINATION OF CONSERVATOR OF PERSON. (A conservator of the person may be appointed for you if a court decides that one should be appointed. The conservator is responsible for your physical care, which under some circumstances includes making health care decisions for you. You are not required to nominate a conservator but you may do so. The court will appoint the person you nominate unless that would be contrary to your best interests. You may, but are not required to, nominate as your conservator the same person you named in paragraph 1 as your health care agent. You can nominate an individual as your conservator by completing the space below.)

If a conservator of the person is to be appointed for me, I nominate the following individual to serve as conservator of the person_____

_____

(Insert name and address of person nominated as conservator of the person)

11. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on _____ (Date) at _____ (City),_____ (State).

_____

(You sign here)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.)

STATEMENT OF WITNESSES

(This document must be witnessed by two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as your agent or alternate agent, (2) a health care provider, (3) an employee of a health care provider, (4) the operator of a community care facility, (5) an employee of an operator of a community care facility, (6) the operator of a residential care facility for the elderly; or (7) an employee of an operator of a residential care facility for the elderly. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)
(READ CAREFULLY BEFORE SIGNING. You can sign as a witness only if you personally know the principal or the identity of the principal is proved to you by convincing evidence.)

(To have convincing evidence of the identity of the principal, you must be presented with and reasonably rely on any one or more of the following:

(1) An identification card or driver's license issued by the California Department of Motor Vehicles that is current or has been issued within five years.

(2) A passport issued by the Department of State of the United States that is current or has been issued within five years.

(3) Any of the following documents if the document is current or has been issued within five years and contains a photograph and description of the person named on it, is signed by the person, and bears a serial or other identifying number:

(a) A passport issued by a foreign government that has been stamped by the United States Immigration and Naturalization Service.

(b) A driver's license issued by a state other than California or by a Canadian or Mexican public agency authorized to issue drivers' licenses.

(c) An identification card issued by a state other than California.

(d) An identification card issued by any branch of the armed forces of the United States.)

(Other kinds of proof of identity are not allowed.)

I declare under penalty of perjury under the laws of California that the person who signed or acknowledged this document is personally known to me (or proved to me on the basis of convincing evidence) to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, an employee of an operator of a community care facility, *the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.*

Signature:_____ Residence Address:_____
Print Name:_____
Date:_____

Signature:_____ Residence Address:_____
Print Name:_____
Date:_____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

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

Signature:_____

Signature:_____

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

(If you are a patient in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman. The following statement is required only if you are a patient in a skilled nursing facility—a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign both parts of the "Statement of Witnesses" above AND must also sign the following statement.)

I further declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by subdivision (f) of Sections 2432 of the Civil Code.

Signature:_____

Connecticut General Statutes § 1-43

General Provisions:

A durable power of attorney for health care in the state of Connecticut must be substantially in the form provided. Although empowered to make health care decisions, the attorney-in-fact may not direct the withholding or withdrawal of therapy required to maintain life.

FORM

CONNECTICUT DURABLE POWERS OF ATTORNEY FOR HEALTH CARE

Notice: The powers granted by this document are broad and sweeping. They are defined in Connecticut Statutory Short Form Power of Attorney Act, sections 1-42 to 1-56, inclusive, of the general statutes, which expressly permits the use of any other or different form of power of attorney desired by the parties concerned.

DURABLE POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, which are intended to constitute a general power of attorney pursuant to Connecticut Statutory Short Form Power of Attorney Act:

That I, _____ [Typed Name of Declarant], residing at _____ [Number] _____ [Street], _____ [Town or City], _____ [State], do hereby appoint _____ [Typed Name Proxy] presently residing at _____ [Number and Street], _____ [Town or City], _____ [State], my attorney-in-fact to act:

FIRST, In my place and stead in any way which I could do, if I were personally present, with respect to the following matters as each of them is defined in the Connecticut Statutory Short Form Power of Attorney Act to the extent that I may be permitted by law to act through an agent.

[Strike out and initial in the opposite box any one or more of the subdivisions as to which the principal does *NOT* desire to give the agent authority. Such elimination of any one or more of subdivision (A) to (L), inclusive, shall automatically constitute an elimination of subdivision (M).]

(A)	real estate transactions;	[ ]
(B)	chattel and goods transactions;	[ ]
(C)	bond, share and commodity transactions;	[ ]
(D)	banking transactions;	[ ]
(E)	business operating transactions;	[ ]
(F)	insurance transactions;	[ ]
(G)	estate transactions;	[ ]
(H)	claims and litigation;	[ ]
(I)	personal relationships and affairs;	[ ]
(J)	benefits from military service;	

[ ]

(K) records, reports and statements; [ ]

(L) health care decisions; [ ]

(M) all other matters; [ ]

(Special provisions and limitations may be included in the statutory short form power of attorney only if they conform to the requirements of the Connecticut Statutory Short Form Power of Attorney Act.)

SECOND: With full and unqualified authority to delegate any or all of the foregoing powers to any person or persons whom my attorney(s)-in-fact shall select;

THIRD: Hereby ratifying and confirming all that said attorney(s) or substitute(s) may do or may cause to be done.

SURVIVAL OF AUTHORITY UPON DISABILITY AND INCOMPETENCE OF PRINCIPALS

This Power of Attorney SHALL NOT be affected by the subsequent disability or incompetence of the principal.

WITNESS, MY HAND this ____ day of _____, 199__.

SIGNED, SEALED AND DELIVERED IN THE PRESENCE OF

Witnesses:

Sign:_____

Print:

Sign:_____

Print:

Principal:

Sign:_____

Print:

STATE OF CONNECTICUT
199__
COUNTY OF } ss._____ _____,
[Town or City] [Date]

The foregoing POWER OF ATTORNEY with provision for SURVIVAL OF AUTHORITY was acknowledged before me this ____ day of _____, 199__.

by_____
Declarant

_____
Printed Name of Notary

Sign:_____
Commissioner of the Superior Court/Notary Public

Seal:

District of Columbia Code § 21-2207

General Provisions:

A durable power of attorney for health care in the District of Columbia may, but need not, employ the form provided. It should be dated and signed by the principal and two adult witnesses who affirm that the principal was of sound mind and free from duress at the time of the signing.

The two adult witnesses shall not include the agent, the health care provider of the principal or an employee of the health care provider of the principal. One of the two witnesses shall not be related to the principal by blood, marriage or adoption and shall not be entitled to any part of the estate of the principal by a current will or operation of law.

FORM

INFORMATION ABOUT THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, IT IS VITAL FOR YOU TO KNOW AND UNDERSTAND THESE FACTS:

THIS DOCUMENT GIVES THE PERSON YOU NAME AS YOUR ATTORNEY IN FACT THE POWER TO MAKE HEALTH-CARE DECISIONS FOR YOU IF YOU CANNOT MAKE THE DECISIONS FOR YOURSELF.

AFTER YOU HAVE SIGNED THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE HEALTH-CARE DECISIONS FOR YOURSELF IF YOU ARE MENTALLY COMPETENT TO DO SO. IN ADDITION, AFTER YOU HAVE SIGNED THIS DOCUMENT NO TREATMENT MAY BE GIVEN TO YOU OR STOPPED OVER YOUR OBJECTION IF YOU ARE MENTALLY COMPETENT TO MAKE THAT DECISION.

YOU MAY STATE IN THIS DOCUMENT ANY TYPE OF TREATMENT THAT YOU DO NOT DESIRE AND ANY THAT YOU WANT TO MAKE SURE YOU RECEIVE.

YOU HAVE THE RIGHT TO TAKE AWAY THE AUTHORITY OF YOUR ATTORNEY IN FACT, UNLESS YOU HAVE BEEN ADJUDICATED INCOMPETENT, BY NOTIFYING YOUR ATTORNEY IN FACT OR HEALTH-CARE PROVIDER EITHER ORALLY OR IN WRITING. SHOULD YOU REVOKE THE AUTHORITY OF YOUR ATTORNEY IN FACT, IT IS ADVISABLE TO REVOKE IN WRITING AND TO PLACE COPIES OF THE REVOCATION WHEREVER THIS DOCUMENT IS LOCATED.

IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A SOCIAL WORKER, LAWYER, OR OTHER PERSON TO EXPLAIN IT TO YOU.

* * * * *

YOU SHOULD KEEP A COPY OF THIS DOCUMENT AFTER YOU HAVE SIGNED IT. GIVE A COPY TO THE PERSON YOU NAME AS YOUR ATTORNEY IN FACT. IF YOU ARE IN A HEALTH-CARE

FACILITY, A COPY OF THIS DOCUMENT SHOULD BE INCLUDED IN YOUR MEDICAL RECORD.

POWER OF ATTORNEY FOR HEALTH CARE

I, _____, hereby appoint:

_____ _____

name home address

_____

home telephone number

_____

work telephone number

as my attorney in fact to make health-care decisions for me if I become unable to make my own health-care decisions. This gives my attorney in fact the power to grant, refuse, or withdraw consent on my behalf for any health-care service, treatment or procedure. My attorney in fact also has the authority to talk to health-care personnel, get information and sign forms necessary to carry out these decisions.

If the person named as my attorney in fact is not available or is unable to act as my attorney in fact, I appoint the following person to serve in the order listed below:

1. _____ _____

name home address

_____ _____

home telephone number

_____ _____

work telephone number

2. _____ _____

name home address

_____ _____

home telephone number

_____ _____

work telephone number

With this document, I intend to create a power of attorney for health care, which shall take effect if I become incapable of making my own health-care decisions and shall continue during that incapacity.

My attorney in fact shall make health-care decisions as I direct below or as I make known to my attorney in fact in some other way.

(a) STATEMENT OF DIRECTIVES CONCERNING LIFE-PROLONGING CARE, TREATMENT, SERVICES, AND PROCEDURES:

_____

_____

_____

_____

_____

_____

_____

(b) SPECIAL PROVISIONS AND LIMITATIONS:

_____

_____

_____

_____

_____

_____

BY MY SIGNATURE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

I sign my name to this form on _____ (date)

at:_____

_____ (address).

_____

(Signature)

WITNESSES

I declare that the person who signed or acknowledged this document is personally known to me, that the person signed or acknowledged this durable power of attorney for health care in my presence, and that the person appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as the attorney in fact by this document, nor an I the health-care provider of the principal or am employee of the health-care provider of the principal.

First Witness

Signature:_____

Home Address:_____

Print Name:_____

Date:_____

Second Witness

Signature:_____

Home Address:_____

Print Name:_____

Date:_____

(AT LEAST 1 OF WITNESSES LISTED ABOVE SHALL ALSO SIGN THE FOLLOWING DECLARATION.)

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

Signature:_____

Signature:_____

Georgia Code § 31-36-10

General Provisions:

A durable power of attorney for health care in the State of Georgia must be substantially in the form provided, but may include additional provisions relating to the delegation of a parent's power to control the health care of a minor child or other provisions consistent with this form. The agency must be in writing and signed by the principal or by some other person in the principal's presence and by the principal's express direction.

A health care agency shall be attested and subscribed in the presence of the principal by two or more competent witnesses who are at least 18 years of age. In addition, if at the time a health care agency is executed the principal is a patient in a hospital or skilled nursing facility, the health care agency shall also be attested to and subscribed in the presence of the principal by the principal's attending physician.

No health care provider may act as an agent under a health care agency if he or she is directly or indirectly involved in the health care rendered to the patient under the health care agency.

FORM

GEORGIA STATUTORY SHORT FORM
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR AGENT) BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU, INCLUDING POWER TO REQUIRE, CONSENT TO, OR WITHDRAW ANY TYPE OF PERSONAL CARE OR MEDICAL TREATMENT FOR ANY PHYSICAL OR MENTAL CONDITION AND TO ADMIT YOU TO OR DISCHARGE YOU FROM ANY HOSPITAL, HOME, OR OTHER INSTITUTION; BUT NOT INCLUDING PSYCHOSURGERY, STERILIZATION, OR INVOLUNTARY HOSPITALIZATION OR TREATMENT COVERED BY TITLE 37 OF THE OFFICIAL CODE OF GEORGIA ANNOTATED. THIS FORM DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS; BUT, WHEN A POWER IS EXERCISED, YOUR AGENT WILL HAVE TO USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS FORM. A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THE AGENT IS NOT ACTING PROPERLY. YOU MAY NAME COAGENTS AND SUCCESSOR AGENTS UNDER THIS FORM, BUT YOU MAY NOT NAME A HEALTH CARE PROVIDER WHO MAY BE DIRECTLY OR INDIRECTLY INVOLVED IN RENDERING HEALTH CARE TO YOU UNDER THIS POWER. UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THIS POWER IN THE MANNER PROVIDED BELOW OR UNTIL YOU REVOKE THIS POWER OR A COURT ACTING ON YOUR BEHALF TERMINATES IT, YOUR AGENT MAY EXERCISE THE POWERS GIVEN IN THIS POWER THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME DISABLED, INCAPACITATED,

OR INCOMPETENT. THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO REVOKE THOSE POWERS, AND THE PENALTIES FOR VIOLATING THE LAW ARE EXPLAINED MORE FULLY IN CODE SECTIONS 31-36-6, 31-36-9, AND 31-36-10 OF THE GEORGIA /DURABLE POWER OF ATTORNEY FOR HEALTH CARE ACT' OF WHICH THIS FORM IS A PART (SEE THE BACK OF THIS FORM). THAT ACT EXPRESSLY PERMITS THE USE OF ANY DIFFERENT FORM OF POWER OF ATTORNEY YOU MAY DESIRE. IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

DURABLE POWER OF ATTORNEY made this ____ day of _____, 19__.

1. I,_____

(insert name and address of principal)

hereby appoint_____

(insert name and address of agent)

as my attorney in fact (my agent) to act for me and in my name in any way I could act in person to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and health care and to require, withhold, or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any part or all of my body for medical purposes, authorize an autopsy of my body, and direct the disposition of my remains.

THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF NOURISHMENT AND FLUIDS AND OTHER LIFE-SUSTAINING OR DEATH-DELAYING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT'S POWERS OR PRESCRIBE SPECIAL RULES TO LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY, OR DISPOSE OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as your own definition of when life-sustaining or death-delaying measures should be withheld; a direction to continue nourishment and fluids or other life-sustaining or death-delaying treatment in all events; or instructions to refuse any specific types of treatment that are inconsis-

tent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electroconvulsive therapy, or amputation):

_____

_____

_____

THE SUBJECT OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT, BUT DO NOT INITIAL MORE THAN ONE:

I do not want my life to be prolonged nor do I want life-sustaining or death-delaying treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life-sustaining or death-delaying treatment.

Initialed_____

I want my life to be prolonged and I want life-sustaining or death-delaying treatment to be provided or continued unless I am in a coma, including a persistent vegetative state, which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered such an irreversible coma, I want life-sustaining or death-delaying treatment to be withheld or discontinued.

Initialed_____

I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures.

Initialed_____

THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU AT ANY TIME AND IN ANY MANNER WHILE YOU ARE ABLE TO DO SO. IN THE ABSENCE OF AN AMENDMENT OR REVOCATION, THE AUTHORITY GRANTED IN THIS POWER OF ATTORNEY WILL BECOME EFFECTIVE AT THE TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH AND WILL CONTINUE BEYOND YOUR DEATH IF ANATOMICAL GIFT, AUTOPSY, OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:

3. ( ) This power of attorney shall become effective on _____ (insert a future date or event during your lifetime,

such as court determination of your disability, incapacity, or incompetency, when you want this power to first take effect).

4. ( ) This power of attorney shall terminate on _____ (insert a future date or event, such as court determination of your disability, incapacity, or incompetency, when you want this power to terminate prior to your death).

IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND ADDRESSES OF SUCH SUCCESSORS IN THE FOLLOWING PARAGRAPH:

5. If any agent named by me shall die, become legally disabled, incapacitated, or incompetent, or resign, refuse to act, or be unavailable, I name the following (each to act successively in the order named) as successors to such agent:

_____

_____

IF YOU WISH TO NAME A GUARDIAN OF YOUR PERSON IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED, YOU MAY, BUT ARE NOT REQUIRED TO, DO SO BY INSERTING THE NAME OF SUCH GUARDIAN IN THE FOLLOWING PARAGRAPH. THE COURT WILL APPOINT THE PERSON NOMINATED BY YOU IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. YOU MAY, BUT ARE NOT REQUIRED TO, NOMINATE AS YOUR GUARDIAN THE SAME PERSON NAMED IN THIS FORM AS YOUR AGENT.

6. If a guardian of my person is to be appointed, I nominate the following to serve as such guardian:

_____

(insert name and address of nominated guardian of the person)

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed_____
(Principal)

The principal has had an opportunity to read the above form and has signed the above form in our presence. We, the undersigned, each being over 18 years of age, witness the principal's signature at the request and in the presence of the principal, and in the presence of each other, on the day and year above set out.

Witnesses: Addresses:

_____ _____

_____

_____ _____

_____

Additional witness required when health care agency is signed in a hospital or skilled nursing facility.

I hereby witness this health care agency and attest that I believe the

principal to be of sound mind and to have made this health care agency willingly and voluntarily.

Witness: _____
Attending Physician

Address: _____
_____

YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.

Specimen signatures of agent and successor(s)	I certify that the signature of my agent and successor(s) is correct.
_____ (Agent)	_____ (Principal)
_____ (Successor agent)	_____ (Principal)
_____ (Successor agent)	_____ (Principal)

Idaho

A power of attorney for health care may be designated under the living will statue to implement the living will.

Illinois Revised Statutes Chapter 110 ½ ¶ 804-10

General Provisions:

A power of attorney for health care in the State of Illinois must be substantially in the form provided.

Neither the attending physician nor any other health care provider may act as an agent under a health care agency; however, a person who is not administering health care to the patient may act as a health care agent for the patient even though the person is a physician or otherwise licensed, certified, authorized, or permitted by the law to administer health care in the ordinary course of business or the practice of a profession.

In Illinois the decisions of a power of attorney hold precedent over the directives of a living will.

FORM

ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE

(NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR "AGENT") BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU, INCLUDING POWER TO REQUIRE, CONSENT TO OR WITHDRAW ANY TYPE OF PERSONAL CARE OR MEDICAL TREATMENT FOR ANY PHYSICAL OR MENTAL CONDITION AND TO ADMIT YOU TO OR DISCHARGE YOU FROM ANY HOSPITAL, HOME OR OTHER INSTITUTION. THIS FORM DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWER; BUT WHEN POWERS ARE EXERCISED, YOUR AGENT WILL HAVE TO USED DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS FORM AND KEEP A RECORD OF RECEIPTS, DISBURSEMENTS AND SIGNIFICANT ACTIONS TAKEN AS AGENT. A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THE AGENT IS NOT ACTING PROPERLY. YOU MAY NAME SUCCESSOR AGENTS UNDER THIS FORM BUT NOT CO-AGENTS, AND NO HEALTH CARE PROVIDER MAY BE NAMED. UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THIS POWER IN THE MANNER PROVIDED BELOW, UNTIL YOU REVOKE THIS POWER OR A COURT ACTING ON YOUR BEHALF TERMINATES IT, YOUR AGENT MAY EXERCISE THE POWERS GIVEN HERE THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME DISABLED. THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO REVOKE THOSE POWERS AND THE PENALTIES FOR VIOLATING THE LAW ARE EXPLAINED MORE FULLY IN SECTIONS 4-5, 4-6, 4-9 AND 4-10 (b) OF THE ILLINOIS "POWERS OF ATTORNEY FOR HEALTH CARE LAW" OF WHICH THIS FORM IS A PART (SEE THE BACK OF THIS FORM). THAT LAW EXPRESSLY PERMITS THE USE OF ANY DIFFERENT FORM

OF POWER OF ATTORNEY YOU MAY DESIRE. IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.)

POWER OF ATTORNEY made this ____ day of _____ (month) _____ (year)

1. I,_____
(insert name and address of principal)
hereby appoint:

_____
(insert name and address of agent)
as my attorney-in-fact (my "agent") to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any part or all of my body for medical purposes, authorize an autopsy and direct the disposition of my remains.

(THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISION YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF FOOD AND WATER AND OTHER LIFE-SUSTAINING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT'S POWERS OR PRESCRIBE SPECIAL RULES OR LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY OR DISPOSE OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.)

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as: your own definition of when life-sustaining measures should be withheld; a direction to continue food and fluids or life-sustaining treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electro-convulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc.):

_____
_____
_____
_____
_____

(THE SUBJECT OF LIFE-SUSTAINING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT; BUT DO NOT INITIAL MORE THAN ONE):

I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

Initialed_____

I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am in a coma which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered irreversible coma, I want life-sustaining treatment to be withheld or discontinued.

Initialed_____

I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of the procedures.

Initialed_____

(THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU IN THE MANNER PROVIDED IN SECTION 4-6 OF THE ILLINOIS "POWERS OF ATTORNEY FOR HEALTH CARE LAW" (SEE THE BACK OF THIS FORM).* ABSENT AMENDMENT OR REVOCATION, THE AUTHORITY GRANTED IN THIS POWER OF ATTORNEY WILL BECOME EFFECTIVE AT THE TIME THIS POWER IS SIGNED AND WILL CONTINUE UNTIL YOUR DEATH, AND BEYOND IF ANATOMICAL GIFT, AUTOPSY OR DISPOSITION OF REMAINS IS AUTHORIZED, UNLESS A LIMITATION ON THE BEGINNING DATE OR DURATION IS MADE BY INITIALING AND COMPLETING EITHER OR BOTH OF THE FOLLOWING:)

3. ( ) This power of attorney shall become effective on

_____

(insert a future date or event during your lifetime, such as court determination of your disability, when you want this power to first take effect)

4. ( ) This power of attorney shall terminate on

_____

(insert a future date or event, such as court determination of you disability, when you want this power to terminate prior to your death)

(IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE

NAMES AND ADDRESSES OF SUCH SUCCESSORS IN THE FOLLOWING PARAGRAPH.)

5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent:

_____

_____

_____

For purposes of this paragraph 5, a person shall be considered to be incompetent if and while the person is a minor or an adjudicated incompetent or disabled person or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.

(IF YOU WISH TO NAME YOUR AGENT AS GUARDIAN OF YOUR PERSON, IN THE EVENT A COURT DECIDES THAT ONE SHOULD BE APPOINTED, YOU MAY, BUT ARE NOT REQUIRED TO, DO SO BY RETAINING THE FOLLOWING PARAGRAPH. THE COURT WILL APPOINT YOUR AGENT IF THE COURT FINDS THAT SUCH APPOINTMENT WILL SERVE YOUR BEST INTERESTS AND WELFARE. STRIKE OUT PARAGRAPH 6 IF YOU DO NOT WANT YOUR AGENT TO ACT AS GUARDIAN.)

6. If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security. (insert name and address of nominated guardian of the person)

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed._____

(principal)

The principal has had an opportunity to read the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence.

_____ Residing at_____

(witness)

(YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.)

Specimen signatures of agent (and successors).	I certify that the signatures of my agent (and successors are correct
_____	_____
(agent)	(principal)

(successor agent)	(principal)
(successor agent)	(principal)

The agent shall have the same right to visit the principal in the hospital or other institution as is granted to a spouse or adult child of the principal, any rule of the institution to the contrary notwithstanding.

* The powers of attorney for health care statute does not indicate what must appear on the back of the form.

Iowa Code § 144B.5

A power of attorney for health care in the State of Iowa may, but need not be, in the following form. It must name an attorney-in-fact who is not a health care provider attending the principal on the date of execution, or an employee of a health care provider attending the principal on the date of execution unless the individual designated is related to the principal by blood, marriage, or adoption within the third degree of consanguinity.

The witnesses of the instrument should not be

(1) A health care provider attending the principal on the date of execution,

(2) An employee of a health care provider attending the principal on the date of execution,

(3) The designated attorney-in-fact, or

(4) Less than 18 years of age.

At least one witness shall be an individual who is not a relative of the principal by blood, marriage, or adoption within the third degree of consanguinity.

. . . . . .

I hereby designate _____ as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending physician, to make those health care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the law of this state, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including to consent, to refuse to consent, or to withdraw consent to the provision of any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of my desires and any limitations included in this document.

My agent has the right to examine my medical records and to consent to disclosure of such records.

Kansas Statutes § 58-632

General Provisions:

A durable power of attorney for health care decisions in the State of Kansas must be in substantially the following form. It must be (1) dated and (2)(a) signed in the presence of two witnesses at least 18 years of age neither of whom shall be the agent, related to the principal by blood, marriage or adoption, entitled to any portion of the estate of the principal according to the laws of intestate succession of this state or under any will of the principal or codicil thereto, or directly financially responsible for the principal's health care; or (b) acknowledged before a notary public.

A durable power of attorney for health care in Kansas may not designate as an agent the treating health care provider, nor an employee of the treating health care provider, nor an employee, owner, director, or officer of a facility described in K.S.A. 1989 Supp. 58-629(a)(2).

FORM

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS GENERAL STATEMENT OF AUTHORITY GRANTED

I, _____, designate and appoint:

Name_____

Address_____

Telephone Number

to be my agent for health care decisions and pursuant to the language stated below, on my behalf to:

(1) Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition, and to make decisions about organ donation, autopsy and disposition of the body;

(2) make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge health care personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists or any other person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care as the agent shall deem necessary for my physical, mental and emotional well being; and

(3) request, receive and review any information, verbal or written, regarding my personal affairs or physical or mental health including medical and hospital records and to execute any releases of other documents that may be required in order to obtain such information.

In exercising the grant of authority set forth above my agent for health care decisions shall:_____

_____

_____

(Here may be inserted any special instructions or statement of the principal's desires to be followed by the agent in exercising the authority granted).

LIMITATIONS OF AUTHORITY

(1) The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney for health care decisions, and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.

(2) The agent shall be prohibited from authorizing consent for the following items:_____

_____

(3) This durable power of attorney for health care decisions shall be subject to the additional following limitations:_____

_____

EFFECTIVE TIME

This power of attorney for health care decisions shall become effective (immediately and shall not be affected by my subsequent disability or incapacity or upon the occurrence of my disability or incapacity).

REVOCATION

Any durable power of attorney for health care decisions I have previously made is hereby revoked.

(This durable power of attorney for health care decisions shall be revoked by and instrument in writing executed, witnessed or acknowledged in the same manner as required herein or set out another manner of revocation, if desired.)

EXECUTION

Executed this _____, at _____, Kansas.

_____

Principal

This document must be: (1) Witnessed by two individuals of lawful age who are not the agent, not related to the principal by blood, marriage or adoption, not entitled to any portion of principal's estate an not financially responsible for principal's health care; OR (2) acknowledged by a notary public.

_____	_____
Witness	Witness
_____	_____
Address	Address

(OR)

STATE OF_____) SS.
COUNTY OF_____)

This instrument was acknowledged before me on _____ (date) by _____ (name of person)

_____
(Signature of notary public)
(Seal, if any)

My appointment expires:_____

Copies

Kentucky Revised Statutes § 311.980

General Provisions:

A designation of a health care surrogate may be in substantially the following form. In addition, the designation may include other specific directions which are in accordance with accepted medical practice and not specifically prohibited.

The designation shall be in writing, dated, and signed by the grantor, or at the grantor's direction, and either witnessed by two or more adults in the presence of the grantor and in the presence of each other, or acknowledged before a notary public or other person authorized to administer oaths, but a person who is then disqualified to act as a surrogate may not be a witness or the notary.

FORM

DESIGNATION OF HEALTH CARE SURROGATE

I designate _____ as my health care surrogate(s) to make any health care decisions for me when I no longer have decisional capacity. If _____ refuses or is not able to act for me, I designate _____ as my health care surrogate(s).

Any prior designation is revoked.

Signed this ____ day of _____, 19__.

Signature and address of the grantor.

In our joint presence, the grantor, who is of sound mind and eighteen years of age, or older, voluntarily dated and signed this writing or directed it to be dated and signed for the grantor.

_____

Signature and address of witness.

_____

Signature and address of witness.

OR

STATE OF KENTUCKY)
_____ County)

Before me, the undersigned authority, came the grantor who is of sound mind and eighteen (18) years of age, or older, and acknowledged that he voluntarily dated and signed this writing or directed it to be signed and dated as above.

Done this ____ day of _____, 19__ _____

Signature of Notary Public or other officer.

Date commission expires:_____

Massachusetts General Laws 201D:1–201D:17

General Provisions:

A health care proxy in the state of Massachusetts shall be in writing signed by such adult or at the direction of such principal in the presence of two other principals who shall subscribe in writing that the principal appeared to be at least 18 years of age, of sound mind and under no constraint or undue influence. No person who has been named as health care agent in a health care proxy shall act as a witness to the execution of such proxy.

No person who is an operator, administrator or employee of a facility may be appointed as a health care agent by an adult, who, at the time of executing the health care proxy is a patient or resident of such facility or has applied for admission to such facility unless said operator, administrator or employee is related to the principal by blood, marriage or adoption.

The following has been suggested for use in Massachusetts.[1] It is not an official form:

FORM

A MODEL HEALTH CARE PROXY FOR USE IN MASSACHUSETTS

I, _____, residing at
(principal—print your name)
_____,
(street) (city or town) (state)
appoint as my Health Care Agent_____
(name of person you choose as agent)
of_____.
(street) (city or town) (state) (phone)
Optional: If my agent is unwilling or unable to serve then I appoint as my alternate_____
(name of person you choose as alternate)
of_____.
(street) (city or town) (state) (phone)

My agent shall have the authority to make all health care decisions for me, subject to any limitations I state below, if I am unable to make decisions myself. My agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions as I would if I had the capacity to make them, except (here list the limitations, if any, you wish to place on your agent's authority):

I direct my agent to make decisions on the basis of my agent's assessment of my personal wishes. If my personal wishes are unknown, my agent is to make decisions on the basis of my agent's assessment of

1. Form suggested by Annas, 324 New Engl J Med 17:1213 (1991).

my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original.

Signed_____

Complete only if principal is physically unable to sign: I have signed the principal's name above at his or her direction in the presence of the principal and two witnesses.

_____

(name)

_____

(street)

_____

(city or town) (state)

WITNESS STATEMENT

We the undersigned, each witnessed the signing of this Health Care Proxy by the principal or at the direction of the principal and state that the principal appears to be at least 18 years of age, of sound mind, and under no constraint or undue influence. Neither of us is named as the health care agent or alternate in this document.

In our presence this ____ day of _____, 199__.

Witness 1_____ Witness 2_____

(signature) (signature)

Name (print)_____ Name (print)_____

Address_____ Address_____

_____ _____

Michigan Compiled Laws § 700.496

A designated health care agent in Michigan is referred to as a "patient advocate." Designation of the patient advocate must be witnessed by two adults who are not the patient's spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of the witnessing, physician, patient advocate, an employee of a life or health insurance provider for the patient, an employee of a health facility that is treating the patient, or an employee of a home for the aged.

The statute does not provide a suggested form but the form employed must include the following information:

(a) This designation shall not become effective unless the patient is unable to participate in medical treatment decisions.

(b) A patient advocate shall not exercise powers concerning the patient's care, custody, and medical treatment that the patient, if the patient were able to participate in the decision, could not have exercised on his or her own behalf.

(c) This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the pregnant patient's death.

(d) A patient advocate may make a decision to withhold or with-draw treatment which would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

(e) A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

(f) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are pre- sumed to be in the patient's best interests.

(g) A patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.

(h) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

(i) A patient admitted to a health facility or agency has the rights enumerated in section 20201 of the Public health code, Act No. 368 of the Public Acts of 1978, being section 333.20201 of the Michigan Compiled Laws.

Mississippi Code §§ 41-41-159, 163, 165

General Provisions:

A durable power of attorney in the State of Mississippi must include the following notice provision, and must be signed by at least two individuals each of whom witnessed either the signing of the instrument by the principal or the principal's acknowledgement of the signature or of the instrument, each witness in substance making the prescribed declaration below.

A treating health care provider or an employee of a treating health care provider may not be designated as the attorney in fact to make health care decisions under a durable power of attorney.

FORM

NOTICE TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document, you should know these important facts:

This document gives the person you designate as the attorney in fact (your agent) the power to make health care decisions for you. This power exists only as to those health care decisions to which you are unable to give informed consent. The attorney in fact must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

The document gives your agent authority to consent, to refuse to consent or to withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any statement of your desires and any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent (a) authorizes anything that is illegal, (b) acts contrary to you known desires or (c) where your desires are not known and does anything that is clearly contrary to your best interests.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital or other health care provider in writing of the revocation.

Your agent has the right to examine your medical records and to consent to this disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to (a) authorize an autopsy, (b) donate your body or parts thereof for transplant or for educational, therapeutic or scientific purposes, and (c) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

This power of attorney will not be valid for making health care decisions unless it is either (a) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature or (b) acknowledged before a notary public in the state.

---

§ 41-41-165.

This section provides in part that, subject to any limitations in the durable power of attorney, the attorney in fact may make health care decisions for the principal, before or after the death of the principal, to the same extent as the principal could make health care decisions for himself or herself if the principal had the capacity to do so, including making a disposition under the state's anatomical gift act; authorizing an autopsy; and directing the disposition of remains.

---

§ 41-41-159.

This section sets forth the requirements for witnessing a health care power of attorney. The following form should be used:

I declare under penalty of perjury under the laws of _____ that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, nor an employee of a health care provider or facility.

In addition, the declaration of at least one (1) of the witnesses must include the following:

I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

This statement must be acknowledged before a notary public at any place within the state, the notary public certifying to the substance of the following:

State of_____

County of_____

On this ____ day of _____, in the year _____, before me, _____ (insert name of notary public) personally appeared

_____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

_____
(Signature of Notary Public)

Notary Seal

Missouri Statutes §§ 404.800–404.865

Authorizes use of the standard durable power of attorney specifically granting health care powers to give consent to or prohibit any type of health care, medical care, treatment or procedure to the extent authorized by the statute.

Under the act the agent may not be an attending physician, an owner or operator of a health care facility, or one of their employees unless:

(1) the patient and attorney in fact are related by affinity or consanguinity within the second degree; or

(2) The patient and attorney in fact are members of the same community of persons who are bound be vows to a religious life and who conduct or assist in the conducting of religious services and actually and regularly engage in religious, benevolent, charitable, or educational ministry, or the performance of health care services. The principal must specifically grant authority to withhold or withdraw artificially supplied nutrition and hydration.

Nebraska Legislative Bill 696 (1992 Neb ALS 696, 1992 Neb Law 696, 1992 Neb LB 696)

A durable power of attorney for health care in the State of Nebraska must be substantially in the form provided. A principal may not name as an attorney in fact for health care: his or her attending physician; an employee of his or her physician or an owner, operator, or employee of a health care provider who is not related to the principal by blood, marriage, or adoption; or a person unrelated to the principal who is presently serving as an attorney in fact for ten or more principals.

The principal's signature and dating or acknowledgment of signature and date must be witnessed by 2 adult witnesses. Neither of the witnesses to a principal's signature may be:

(a) the principal's spouse, parent, child, grandchild, sibling, presumptive heir, or known devisee at the time of the witnessing;

(b) the attending physician;

(c) an employee of a life or health insurance provider for the principal; or

(d) the attorney in fact.

No more than one witness shall be an administrator or employee of a health care provider who is caring for or treating the principal. Sec. 8. (1) A power of attorney for health care executed on or after January 1, 1993, shall be substantially in the form provided in this subsection.

POWER OF ATTORNEY FOR HEALTH CARE

I appoint _____ whose address is _____, and whose telephone number is _____ as my attorney in fact for health care. I appoint _____ whose address is _____, and whose telephone number is _____ as my successor attorney in fact for health care. I authorize my attorney in fact appointed by this document to make health care decisions for me when I am determined to be incapable of making my own health care decisions. I have read the warning which accompanies this document and understand the consequences of executing a power of attorney for health care.

I direct that my attorney in fact comply with the following instructions or limitations:_____

_____

I direct that my attorney in fact comply with the following instructions on life-sustaining treatment:_____

_____

I direct that my attorney in fact comply with the following instructions on artificially administered nutrition and hydration: (Optional)_____

_____

_____

(Signature of person making designation/date)

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney in fact by this document.

Witnessed By:

Signature of Witness/Date	Printed Name of Witness
Signature of Witness/Date	Printed Name of Witness

WARNING TO PERSON EXECUTING A POWER OF ATTORNEY FOR HEALTH CARE

This is an important legal document. It creates a power of attorney for health care. Before signing this document you should know these important facts:

(a) This document gives the person you designate as your attorney in fact the power to make health care decisions for you when you are determined to be incapacitated. Although not necessary and neither encouraged nor discouraged, you may wish to state instructions or wishes and limit the authority of your attorney in fact.

(b) Subject to the limitation stated in subdivision (d) of this document, the person you designate as your attorney in fact has a duty to act consistently with your desires as stated in this document or otherwise made known by you or, if your desires are unknown, to act in a manner consistent with your best interests. The person you designate in this document does, however, have the right to withdraw from this duty at any time;

(c) You may specify that any determination that you are incapable of making health care decisions must be confirmed by a second physician;

(d) The person you designate as your attorney in fact will not have the authority to consent to the withholding or withdrawal of life-sustaining procedures or of artificially administered nutrition or hydration unless you give him or her that authority in this power of attorney for health care or in some other clear and convincing manner;

(e) This power of attorney for health care should be reviewed periodically. It will continue in effect indefinitely unless you exercise your right to revoke it. You have the right to revoke this power of attorney at any time while you are competent by notifying the attorney in fact or your health care provider of the revocation orally or in writing;

(f) Despite any provision in this power of attorney for health care,

you have the right to make health care decisions for yourself as long as you are not incapable of making those decisions; and

(g) If there is anything in this power of attorney for health care you do not understand, you should seek legal advise. This power of attorney for health care will not be valid for making health care decisions unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

Nevada Revised Statutes § 449.830

General Provisions:

A durable power of attorney for health care in the State of Nevada must be substantially in the form provided. A principal may not name as an attorney in fact in a power of attorney: his or her provider of health care; an employee of his provider of health care; an operator of a health care facility; or an employee of a health care facility.

The principal's signature on the power of attorney must: (a) be acknowledged before a notary public; or (b) witnessed by 2 adult witnesses who knew the principal personally. Neither of the witnesses to a principal's signature may be:

(a) a provider of health care;

(b) an employee of a provider of health care;

(c) an operator of a health care facility;

(d) an employee of a health care facility; or

(e) the attorney in fact.

FORM

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR ATTORNEY-IN-FACT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENT OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE CONSENT, REFUSAL OF CONSENT, OR WITHDRAWAL OF CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT OR PLACEMENTS THAT YOU DO NOT DESIRE.

2. THE PERSON YOU DESIGNATE IN THIS DOCUMENT HAS A DUTY TO ACT CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR BEST INTERESTS.

3. EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THE POWER OF THE PERSON YOU DESIGNATE TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT WHICH WOULD KEEP YOU ALIVE.

4. UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST INDEFINITELY FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

5. NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTH CARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED IF YOU OBJECT.

6. YOU HAVE THE RIGHT TO REVOKE THE APPOINTMENT OF THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THAT PERSON OF THE REVOCATION ORALLY OR IN WRITING.

7. YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY GRANTED TO THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THE TREATING PHYSICIAN, HOSPITAL, OR OTHER PROVIDER OF HEALTH CARE ORALLY OR IN WRITING.

8. THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

9. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

10. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

1. DESIGNATION OF HEALTH CARE AGENT.

I_____

(insert your name) do hereby designate and appoint:

Name:_____

Address:_____

Telephone Number:_____

as my attorney-in-fact to make health care decisions for me as authorized in this document.

(Insert the name and address of the person you wish to designate as your attorney-in-fact to make health care decisions for you. None of the following may be designated as your attorney-in-fact: (1) your treating provider of health care, (2) an employee of your treating provider of health care, (3) an operator of a health care facility, or (4) an employee of an operator of a health care facility.)

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

By this document I intend to create a durable power of attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED.

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS.

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on his or her attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

_____

_____

_____

_____

5. DURATION.

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this power of attorney end on the following date:

_____

6. STATEMENT OF DESIRES.

(With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required

to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.)

(If the statement reflects your desires, initial the box next to the statement.)

1. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures. [_____]

2. If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS [449.610 ET SEQ.] 449.540 to 449.690 inclusive and sections 2 to 12, inclusive, of this act if this subparagraph is initialed. [_____]

3. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS [449.610 ET SEQ.] 449.540 to 449.690 inclusive and sections 2 to 12, inclusive, of this act if this subparagraph is initialed.) [_____]

4. I direct my attending physician not to withhold or withdraw artificial nutrition and hydration by way of the gastro-intestinal tract if such a withholding or withdrawal would result in my death by starvation or dehydration. [_____]

5. I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life. [_____]

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Other or Additional Statements of Desires:_____

_____

_____

_____

_____

_____

7. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT.

(You are not required to designate any alternative attorney-in-fact but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1, page 2, in the event that he or she is unable or unwilling to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A.First Alternative Attorney-in-fact

Name:_____

Address:_____

_____

Telephone Number:_____

B. Second Alternative Attorney-in-fact

Name:_____

Address:_____

_____

Telephone Number:_____

8. PRIOR DESIGNATIONS REVOKED.

I revoke any prior durable power of attorney for health care.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Durable Power of Attorney for Health care on _____(date) at _____(city), _____(state).

_____

(Signature)

(THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of the statement of witnesses.)

State of Nevada
County of_____ } ss.

On this _____ day of _____, in the year._____, before me, _____ (here insert name of notary public) personally appeared _____.(here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

NOTARY SEAL

_____
(Signature of Notary Public)

STATEMENT OF WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized you must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the attorney-in-fact, (2) a provider of health care, (3) an employee of a provider of health care, (4) the operator of health care facility, (5) an employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a provider of health care, an employee of a provider of health care, the operator of a community care facility, nor an employee of an operator of a health care facility.

Signature:_____ Residence Address:_____
Print Name:_____ _____
Date:_____ _____

Signature:_____ Residence Address:_____
Print Name:_____ _____
Date:_____ _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I declare under penalty of perjury that I am not related to the

principal by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature:_____

Signature:_____

. . . . . .

Names:_____ Address:_____

Print Name:_____ _____

Date:_____ _____

COPIES: You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be available so a copy may be given to your providers of health care.

(Added to NRS by 1987, 915)

New Hampshire Revised Statutes §§ 137-J:14, 137-J:15

The principal must be given notice provisions prescribed by the state and must be in substantially the following form:

INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT YOU SHOULD KNOW THESE IMPORTANT FACTS:

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 by physically harmful to you or prolong severe pain which cannot be alleviated by medication.

You may state in this document 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. You may attach additional pages if you need more space to complete your statement.

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.

It is important that you discuss this document with your physician or other health care providers 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. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as 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.

You should inform the person you appoint that you want him or her to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who 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.

This document may not be changed or modified. If you want to make changes in the document you must make an entirely new one.

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 VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO (2) OR MORE QUALIFIED WITNESSES WHO MUST BOTH BE PRESENT WHEN YOU SIGN AND ACKNOWLEDGE YOUR SIGNATURE. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

—the person you have designated as your agent;

—your spouse;

—your lawful heirs or beneficiaries named in your will or a deed;

ONLY ONE OF THE TWO WITNESSES MAY BE YOUR HEALTH OR RESIDENTIAL CARE PROVIDER OR ONE OF THEIR EMPLOYEES.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, hereby appoint _____ of _____ 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. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS REGARDING HEALTH CARE DECISIONS.

For your convenience in expressing your wishes, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. (Life-sustaining treatment is defined as procedures without which a person would die, such as but not limited to the following: cardiopulmonary resuscitation, mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions, and antibiotics.) There is also a section which allows you to set forth specific directions for these or other matters. If you wish you may indicate your agreement or disagreement with any of the following statements and give your agent power to act in those specific circumstances.

1. 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. (YES) (NO) (Circle your choice and initial beneath it.)

2. Whether terminally ill or not, if I become permanently unconscious I authorize my agent to direct that life-sustaining treatment. be discontinued. (YES) (NO) (Circle your choice and initial beneath it.)

3. 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 above in #1 or #2 or any instructions I may write in 4 below, I authorize my agent to direct that (circle your choice of (a) or (b) and initial beside it):

(a) artificial nutrition and hydration not to be started or, if started, be discontinued,

-or-

(b) although all other forms of life-sustaining treatment be withdrawn, artificial nutrition and hydration continue to be given to me. (If you fail to complete item 3, your agent will not have the power to direct the withdrawal of artificial nutrition and hydration.)

4. Here you may include any specific desires or limitations you deem appropriate, such as when or what life-sustaining treatment you would want used or withheld, or instructions about refusing any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. You may leave this question blank if you desire.

_____

_____

_____

_____

_____

(attach additional pages as necessary)

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

_____ of _____

as alternate agent.

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.

The original of this document will be kept at _____ and the following persons and institutions will have signed copies: _____

_____

In witness whereof, I have hereunto signed my name this _____ day of _____ 19____

_____

Signature

I declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that the principal has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

Witness: _____ Address: _____

Witness: _____ Address: _____

STATE OF NEW HAMPSHIRE
COUNTY OF _____

The foregoing instrument was acknowledged before me this ____ day of _____ 19____ by _____

_____

Notary Public/Justice of the Peace
My Commission Expires:

New Jersey Statutes §§ 26:2H-53–26:2H-78

A statutory "proxy directive" naming another with the power to make decisions to forsake medical care is provided for under the New Jersey Advance Directive for Health Care Act in 1991. No form is provided.

Any competent adult may execute an advance directive at any time. The advance directive may be signed and dated before two witnesses, neither of whom is an appointed agent, or before a notary public, attorney at law, or other person authorized to administer oaths. It may be supplemented by a video or audio tape recording. A female declarant may include information as to what effect the advance directive shall have if she is pregnant.

An agent may not be an operator, administrator or employee of a health care institution in which the declarant is a patient or resident unless they are related to the declarant by blood, marriage or adoption. A physician may act as the health care representative if he or she is not serving as the attending physician at the same time.

The declarant may also name alternative representatives and may leave specific instructions.

New York Consolidated Laws, Public Health Law § 2981

General Provisions:

A health care proxy in the State of New York may, but need not, be in the form provided. Another person may sign and date the health care proxy for the adult if the adult is unable to do so, at the adult's direction and in the adult's presence, and in the presence of two adult witnesses who must also sign the proxy. The witness shall state that the principal appeared to execute the proxy willingly and free from duress. The person appointed as a agent shall not act as a witness to the execution of the health care proxy.

The health care proxy shall not be executed on a form or other writing that also includes the execution of a power of attorney, but the act does not invalidate a delegation of the authority to make health care decisions executed prior to its enactment.

FORM

Health Care Proxy

I (name of principal) hereby appoint (name, home address and telephone number of agent) as my health care agent to make any and all health care decisions for me, except to the extent I state otherwise.

This health care proxy shall take effect in the event I become unable to make my own health care decisions.

NOTE: Although not necessary, and neither encouraged nor discouraged, you may wish to state instructions or wishes, and limit your agent's authority. Unless your agent knows your wishes about artificial nutrition and hydration, your agent will not have authority to decide about artificial nutrition and hydration. If you choose to state instructions, wishes, or limits, please do so below:

_____

_____

_____

I direct my agent to make health care decisions in accordance with my wishes and instructions as stated above or as otherwise known to him or her. I also direct my agent to abide by any limitations on his or her authority as stated above or as otherwise known to him or her.

In the event the person I appoint above is unable, unwilling or unavailable to act as my health care agent, I hereby appoint (name, home address and telephone number of alternate agent) as my health care agent.

I understand that, unless I revoke it, this proxy will remain in effect indefinitely or until the date or occurrence of the condition I have stated below:

(Please complete the following if you do NOT want this health care proxy to be in effect indefinitely):

This proxy shall expire: (Specify date or condition)

Signature: _____
Address: _____
Date: _____

I declare that the person who signed or asked another to sign this document is personally known to me and appears to be of sound mind and acting willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence and that person signed in my presence. I am not the person appointed as agent by this document.

Witness: _____
Address: _____
Witness: _____
Address: _____

North Carolina General Statutes § 32A-25

The following is a suggested form for granting a power of attorney for health care in the State of North Carolina. Witness requirements are indicated on the form:

Notice: This document gives the person you designate your health care agent broad powers to make health care decisions for you, including the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive. This power exists only as to those health care decisions for which you are unable to give informed consent.

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will have to use due care to act in your best interests and in accordance with this document. Because the powers granted by this document are broad and sweeping, you should discuss your wishes concerning life-sustaining procedures with your health care agent.

Use of this form in the creation of a health care power of attorney is lawful and is authorized pursuant to North Carolina law. However, use of this form is an optional and nonexclusive method for creating a health care power of attorney and North Carolina law does not bar the use of any other or different form of power of attorney for health care that meets the statutory requirements.

1. Designation of health care agent.

I, _____, being of sound mind, hereby appoint

Name:_____

Home Address_____

Home Telephone Number_____ Work Telephone Number_____

as my health care attorney-in-fact (hereinafter referred to as my health care attorney-in-fact (herein referred to as my "health care agent") to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document.

If the person named as my health care agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following persons (each to act alone and successively, in the order named), to serve in that capacity: (Optional)

A. Name_____
   Home Address_____
   Home Telephone Number_____
   Work Telephone Number_____
B. Name_____
   Home Address_____
   Home Telephone Number_____
   Work Telephone Number_____

Each successor health care agent designated shall be vested with the same power and duties as if originally named as my health care agent.

2. Effectiveness of appointment.

(Notice: This health care power of attorney may be revoked by you at

any time in any manner by which you are able to communicate your intent to revoke to your health care agent and your attending physician.)

Absent revocation, the auhtority granted in this document shall become effective when and if the physician or physicians designated below determine that I lack sufficient understanding or capacity to make or communicate decisions relating to my health care and will continue in effect during my incapacity, until my death. This determination shall be made by the following physician or physicians (You may include here a designation of your choice, including your attending physician, or any other physician. You may also name two or more physicians, if desired, both of whom must make this determination before the authority granted to the health care agent becomes effective.):

_____

_____

_____

_____

3. General statement of authority granted.

Except as indicated in section 4 below, I hereby grant to my health care agent named above full power and authority to make health care decisions on my behalf, including, but not limited to, the following:

A. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information;

B. To employ or discharge my health care providers;

C. To consent to and authorize my admission to and discharge from a hospital, nursing or convalescent home, or other institution;

D. To give consent for, to withdraw consent for, or to withhold consent for, X ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, or podiatrist. This authorization specifically includes the power to consent to measures for relief of pain.

E. To authorize the withholding or withdrawal of life-sustaining procedures when and if my physician determines that I am terminally ill, permanently in a coma, suffer severe dementia, or am in a persistent vegetative state. Life-sustaining procedures are those forms of medical care that only serve to artifically prolong the dying process and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of medical treatment which sustain, restore or supplant vital bodily functions. Life-sustaining procedures do not include care necessary to provide comfort or alleviate pain.

I DESIRE THAT MY LIFE NOT BE PROLONGED BY LIFE-SUSTAINING PROCEDURES IF I AM TERMINALLY ILL, PERMANENTLY IN A COMA, SUFFER SEVERE DEMENTIA, OR AM IN A PERSISTENT VEGETATIVE STATE.

F. To exercise any right I may have to make a disposition of any part or all of my body for medical purposes, to donate my organs, to authorize an autopsy, and to direct the disposition of my remains.

G. To make any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

4. Special provisions and limitations.

(Notice: The above grant of power is intended to be as broad as possible so that your health care agent will have authority to make any decisions you could make to obtain or terminate any type of health care. If you wish to limit the scope of your health care agent's powers, you may do so in this section.

In exercising the authority to make health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions and limitations (Here you may include any specific limitations you deem appropriate such as: your own definition of when life-sustaining treatment should be withheld or discontinued, or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs, or unacceptable to you for any other reason.):

_____

_____

_____

_____

5. Guardianship provision.

If it becomes necessary for a court to appoint a guardian of my person, I nominate my health care agent acting under this document to be the guardian of my person, to serve without bond or security.

6. Reliance of third parties on health care agent.

A. No person who relies in good faith upon the authority of or any representations by my health care agent shall be liable to me, my estate, my heirs, successors, assigns, or personal representatives, for actions or omissions by my health care agent.

B. The powers conferred on my health care agent by this document may be exercised by my health care agent alone, and my health care agent's signature or act under the authority granted in this document may be accepted by persons as fully authorized by me and with the same force and effect as if I were personally present, competent, and acting on my own behalf. All acts performed in good faith by my health care agent pursuant to this power of attorney are done with my

consent and shall have the same validity and effect as if I were present and exercised the pwoers myself, and shall inure to the benefit of and bind me, my estate, my heirs, successors, assigns, and personal representatives. The authority of my health care agent pursuant to this power of attorney shall be superior to and binding upon my family, relatives, friends, and others.

7. Miscellaneous provisions.
   A. I revoke any prior health care power of attorney.
   B. My health care agent shall be entitled to sign, execute, deliver, and acknowledge any contract or other document that may be necessaary, desirable, convenient, or proper in order to exercise and carry out any of the powers described in this document and to incur reasonable costs on my behalf incident to the exercise of these powers; provided, however, that except as shall be necessary in order to exercise the powers described in this document relating to my health care, my health care agent shall not have any authority over my property or financial affairs.
   C. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, and assigns and personal representatives from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my health care agent pursuant to this document, except for wilful misconduct or gross negligence.
   D. No act or omission of my health care agent, or of any other person, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this health care power of attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this health care power of attorney may interpose this document as a defense.
8. Signature of principal.

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

_____ _____

Sigature of Principal Date

9. Signatures of Witnesses.

I hereby state that the Principal _____, being of sound mind, signed the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of

the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor an employee of the principal's attending physician, nor an employee of the health facility in which the principal is a patient, nor an employee of a nursing home or any group care home where the principal resides. I further state that I do not have any claim against the principal.

Witness:_____ Date_____

Witness:_____ Date_____

STATE OF NORTH CAROLINA
COUNTY OF _____

CERTIFICATE

I _____ a Notary Public for _____ County, North Carolina, hereby certify that _____ appeared before me and swore to me and to the witnesses in my presence that this instrument is a health care power of attorney, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that _____ and _____, witnesses, appeared before me and swore that they witnessed _____ sign the attached health care power of attorney, beleiving him/her to be of sound mind; and also swore that at the time they witnessed the signing (i) they were not related within third degree to him/her or his/her spouse, and (ii) they did not know nor have a reasonable expectation that they would be entitled to any portion of his/her estate upon his/her death under any will or codicil thereto then existing or under the Intestate Succession Act as it provided at that time, and (iii) they were not a physician attending him/her, nor an employee of and attending physician, nor an employee of a health facility in which he/she was a patient, nor an employee of a nursing home or any group-care home in which he/she resided, and (iv) they did not have a claim against him/her. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This the ____ day of _____, 19__

_____
Notary Public

My Commission Expires:

_____

(A copy of this form should be given to your health care agent and any alternate named in this power of attorney, and to your physician and family members.)

I _____ agree to act as health care agent for _____, pursuant to this health care power of attorney.

This the ____ day of _____, 19__

North Dakota Century Code § 23-06.5-17

The statutory form durable power of attorney for health care is the preferred form, but is not required. Qualifications regarding the agent are included in provision 1. and qualifications regarding witnesses are included under "Statement of Witnesses" below.

STATUTORY FORM DURABLE POWER OF ATTORNEY
FOR HEALTH CARE WARNING TO PERSON
EXECUTING THIS DOCUMENT

This is an important legal document which is authorized by the general laws of this state. Before executing this document, you should know these important facts:

You must be at least eighteen years of age and a resident of the state of North Dakota for this document to be legally valid and binding.

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision.

This document gives your agent authority to request, consent to, refuse to consent to, or to withdraw consent for any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition if you are unable to do so yourself. This power is subject to any statement of your desires and any limitation that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent authorizes anything that is illegal; acts contrary to your known desires; or where your desires are not known, does anything that is clearly contrary to your best interest.

Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

This document revokes any prior durable power of attorney for health care.

You should carefully read and follow the witnessing procedure

described at the end of this form. This document will not be valid unless you comply with the witnessing procedure.

If there is anything in this document that you do not understand. you should ask a lawyer to explain it to you.

Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents, if any, or give each of them an executed copy of this document. You should give your doctor an executed copy of this document.

1. DESIGNATION OF HEALTH CARE AGENT. I,_____

_____

(insert your name and address)

do hereby designate and appoint:_____

_____

(insert name, address, and telephone number of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: your treating healthcare provider, a nonrelative employee of your treating health care provider, an operator of a long-term care facility, or a nonrelative employee of an operator of a long-term care facility.) as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney for health care.
3. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

   (If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations in paragraph 4, "Statement of Desires, Special Provisions, and Limitations", below. You can indicate your desires by including a statement of your desires in the same paragraph.)
4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. (Your agent must make health care decisions that are consistent with your known desires. You can, but are not required

to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

a. Statement of desires concerning life-prolonging treatment, services, and procedures:

_____

_____

_____

b. Additional statement of desires, special provisions, and limitations regarding health care decisions:

_____

_____

_____

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.) If you wish to make gift of any bodily organ you may do so pursuant to North Dakota Century Code chapter 23-06.2, the Uniform Anatomical Gift Act.

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

   a. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

   b. Execute on my behalf any releases or other documents that may be required in order to obtain this information.

   c. Consent to the disclosure of this information.

   (If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4, "Statement of Desires, Special Provisions, and Limitations", above.)

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:
   a. Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."
   b.mAny necessary waiver or release from liability required by hospital or physician.
7. DURATION. (Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.)
   This durable power of attorney for health care expires on

   _____

   (Fill in this space ONLY if you want the authority of your agent to end on a specific date.)
8. DESIGNATION OF ALTERNATE AGENTS. (You 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 health care decisions as the agent you designated in paragraph 1, above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved. Your agent may withdraw whether or not you are capable of designating another agent.)
   If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:
   a. First Alternate Agent:_____

      _____

      (Insert name, address, and telephone number of first alternate agent.)
   b. Second Alternate Agent:_____

      _____

      (Insert name, address, and telephone number of second alternate agent.)
9. PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL
(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney For Health Care on _____ (date) at _____ (city) _____ (state)

_____

(you sign here)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY TWO (2) QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.)

STATEMENT OF WITNESSES

This document must be witnessed by two (2) qualified adult witnesses. None of the following may be used as a witness:

1. A person you designate as your agent or alternate agent;
2. A health care provider;
3. An employee of a health care provider;
4. The operator of a long-term care facility;
5. An employee of an operator of a long-term care facility;
6. Your spouse;
7. A person related to you by blood or adoption;
8. A person entitled to inherit any part of your estate upon your death; or
9. A person who has, at the time of executing this document, any claim against your estate.

I declare under penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider; the operator of a long-term care facility; an employee of an operator of a long-term care facility; the principal's spouse; a person related to the spouse by blood or adoption, a person entitled to inherit any part of the principal's estate upon death; nor a person who has, at the time of executing this document any claim against the principal's estate.

Signature:_____ Residence Address:_____
Print Name:_____ _____
Date:_____ _____
Signature:_____ Residence Address:_____
Print Name:_____ _____
Date:_____ _____

10. ACCEPTANCE OF APPOINTMENT OF POWER OF ATTORNEY. I accept this appointment and agree to serve as agent for

health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapable. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal may revoke this power of attorney at any time in any manner.

If I choose to withdraw during the time the principal is competent I must notify the principal of my decision. If I choose to withdraw when the principal is incapable of making the principal's health care decisions, I must notify the principal's physician.

_____

(Signature of agent/date)

_____

(Signature of alternate agent/ date)

Ohio Revised Code § 1337.17

General Provisions:

A durable power of attorney for health care in the State of Ohio may be sold in printed form for use by individuals who are not advised by an attorney. If such form is not executed by an attorney than it may not be used as any other form of power of attorney and must include the notice provision below. There is no specific recommended form.

A durable power of attorney for health care must be witnessed by at least two eligible adults. To be eligible, the witness may not be one of the following people:

(1) related to the principal by blood, marriage, or adoption;
(2) the attorney in fact in the instrument;
(3) the attending physician of the principal; or
(4) the administrator of any nursing home in which the principal is receiving care.

Instead of witnesses, the durable power of attorney may be acknowledged by a notary public that attests that the principal appears to be of sound mind and not under or subject to duress, fraud, or undue influence.

FORM

Notice to Adult Executing This Document

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make most health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact generally will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you generally will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

However, EVEN IF THE ATTORNEY IN FACT HAS GENERAL AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR YOU

UNDER THIS DOCUMENT, THE ATTORNEY IN FACT NEVER will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standard, that either of the following applies:

(a) You are suffering from an irreversible, incurable, and untreatable condition caused by disease, illness or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if he is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). (You should understand that comfort care is defined in Ohio law to mean artificially or technologically administered sustenance (nutrition) or fluids (hydration) when administered to diminish your pain or discomfort, not to postpone your death, and any other medical or nursing procedure, treatment, intervention, or other measure that would be taken to diminish your pain or discomfort, not to postpone your death. Consequently, if your attending physician were to determine that a previously described medical or nursing procedure, treatment, intervention, or other measure will not or no longer will serve to provide comfort to you or alleviate your pain, then, subject to (4) below, your attorney in fact would be authorized to refuse or withdraw informed consent to the procedure, treatment, intervention, or other measure);

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) Refuse or withdraw informed consent to the provision of artifi-

cially or technologically administered sustenance (nutrition) or fluids (hydration) to you, unless

(a) You are in a terminal condition or in a permanently unconscious state.

(b) Your attending physician and at least one other physician who has examined you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain.

(c) If, but only if, you are in a permanently unconscious state, you authorize the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you by doing both of the following in this document.

(i) Including a statement in capital letters that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state and if the determination that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate you pain is made, or checking or otherwise marking a box or line (if any) that is adjacent to a similar statement on this document;

(ii) Placing your initials or signature underneath or adjacent to the statement, check, or other mark previously described.

(d) Your attending physician determines, in good faith, that you authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition and hydration to you if you are in a permanently unconscious state by complying with the requirements of (4)(c)(i) and (ii) above.

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising his authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to him in another manner.

When acting pursuant to this document, the attorney in fact generally will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Generally, you may designate any competent adult as the attorney in fact under this document. However, you cannot designate your attending physician, or the administrator of any nursing home in which you are receiving care as the attorney in fact under this

document. Additionally, you cannot designate an employee or agent of your attending physician or an employee or agent of a health care facility at which you are being treated as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care generally will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicate it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption, may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

Oregon Revised Statutes § 127.530

General Provisions:

A power of attorney for health care in the State of Oregon must be in the following form provided. It must specifically authorize the attorney in fact to make health care decisions; and must contain the date of its execution and be witnessed by at least two adults, each of whom witnessed either the signing of the instrument by the principal or the principal's acknowledgement of the signature of the principal.

Each witness shall make the written declaration set forth in the form provided in ORS127.530. At least one of the witnesses shall be a person who is none of the following:

(1) a relative of the principal by blood, marriage, or adoption; or

(2) a person who at the time of execution of the power of attorney would be entitled to any portion of the estate of the principal upon death under any will or by operation of law. The attorney in fact for health care may not be a witness.

None of the following may serve as an attorney in fact:

(1) the attending physician or an employee of the attending physician who is unrelated to the principal by blood, marriage, or adoption; or

(2) a person unrelated to the principal by blood, marriage, or adoption who is an owner, operator or employee of a health care facility in which the principal is a patient or resident.

To be effective the attorney in fact must accept the appointment in writing.

FORM

WARNING TO PERSON APPOINTING A POWER OF ATTORNEY FOR HEALTH CARE

This is an important legal document. It creates a power of attorney for health care. Before signing this document you should know these important facts:

This document gives the person you designate as your attorney-in-fact the power to make health care decisions for you, subject to any limitations, specifications or statement of your desires that you include in this document.

For this document to be effective, your attorney-in-fact must accept the appointment in writing.

The person you designate in this document has a duty to act consistently with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in a manner consistent with what the person in good faith believes to be in your best interest. The person you designate in this document does, however, have the right to withdraw from this duty at any time.

This power will continue in effect for a period of seven years unless you become unable to participate in health care decisions for yourself during that period. If this occurs, the power will continue in effect until you are able to participate in those decisions again.

You have the right to revoke the appointment of the person designated in this document at any time by notifying that person or your health care provider of the revocation orally or in writing.

Despite this document, you have the right to make medical and other health care decisions for yourself as long as you are able to participate knowledgeably in those decisions.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This power of attorney will not be valid for making health care decisions unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

POWER OF ATTORNEY FOR HEALTH CARE

I appoint _____, whose address is _____, and whose telephone number is _____, as my attorney-in-fact for health care decisions. I appoint _____, whose address is _____, and whose telephone number is _____, as my alternative attorney-in-fact for health care decisions. I authorize my attorney-in-fact appointed by this document to make health care decisions for me when I am incapable of making my own health care decisions. I have read the warning below and understand the consequences of appointing a power of attorney for health care.

I direct that my attorney-in-fact comply with the following instructions or limitations:_____

_____

In addition, I direct that my attorney-in-fact have authority to make decisions regarding the following:

_____ Withholding or withdrawal of life-sustaining procedures with the understanding that death may result.

_____ Withholding or withdrawal of artificially administered hydration or nutrition or both with the understanding that dehydration, malnutrition and death may result.

_____

(Signature of person making appointment/Date)

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is the person appointed as attorney-in-fact by this document or the principal's attending physician. Witnessed By:

(Signature of Witness/Date) (Printed Name of Witness)

(Signature of Witness/Date) (Printed Name of Witness)

ACCEPTANCE OF APPOINTMENT OF
POWER OF ATTORNEY

I accept this appointment and agree to serve as attorney-in-fact for health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapable. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal may revoke this power of attorney at any time in any manner, and that I have a duty to inform the principal's attending physician promptly upon any revocation.

(Signature of Attorney-in-fact/Date)

(Printed name)

(Signature of Alternate Attorney-in-fact/Date)

(Printed name)

Rhode Island General Laws § 24-4.10-2

General Provisions:

A durable power of attorney for health care must be in the form provided.

FORM

STATUTORY FORM DURABLE POWER OF ATTORNEY FOR HEALTH CARE

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document which is authorized by the general laws of this state. Before executing this document, you should know these important facts:

You must be at least eighteen (18) years of age and a resident of the state of Rhode Island for this document to be legally valid and binding.

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection at the time, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitation that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of the agent to make health care decisions for you if your agent:

(1) Authorizes anything that is illegal,

(2) Acts contrary to your known desires, or

(3) Where your desires are not known, does anything that is clearly contrary to your best interests.

Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

This document revokes any prior durable power of attorney for health care.

You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents or give each of them an executed copy of this document. You may also want to give your doctor an executed copy of this document.

(1) DESIGNATION OF HEALTH CARE AGENT. I,_____

_____

_____

(insert your name and address)

do hereby designate and appoint:_____

_____

(insert name, address, and telephone number of one individual only as your agent to make health care decisions for you. None of the following may be designated as your agent: (1) your treating health care provider, (2) a nonrelative employee of your treating health care provider, (3) an operator of a community care facility, or (4) a nonrelative employee of an operator of a community care facility.) as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

(2) CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this document I intend to create a durable power of attorney for health care.

(3) GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures.

(If you want to limit the authority of your agent to make health care decisions for you, you can state the limitation in paragraph 4 ("Statement of Desires, Special Provisions, and Limitations") below. You can indicate your desires by including a statement of your desires in the same paragraph.)

(4) STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. (Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

(a) Statement of desires concerning life-prolonging care, treatment, services, and procedures:

_____
_____
_____
_____
_____
_____
_____
_____

(b) Additional statement of desires, special provisions, and limitations regarding health care decisions:

_____
_____
_____
_____
_____
_____
_____
_____

(You may attach additional pages if you need more space to complete you statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.) If you wish to make a gift of any bodily organ you may do so pursuant to the Uniform Anatomical Gift Act.

(5) INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any

limitations in this document, my agent has the power and authority to do all of the following:

(a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

(b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph 4 ("Statement of desires, special provisions, and limitations") above.)

(6) SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

(a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

(b) Any necessary waiver or release from liability required by a hospital or physician.

(7) DURATION. (Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.)

This durable power of attorney for health care expires on

_____

(Fill in this space ONLY if you want authority of your agent to end on a specific date.)

(8) DESIGNATION OF ALTERNATE AGENTS.

(You 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 health care decisions as the agent you designated in paragraph 1, above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

(A) First Alternate Agent:_____

_____

(Insert name, address, and telephone number of first alternate agent.)

(B) Second Alternate Agent:_____

_____

(Insert name, address, and telephone number of second alternate agent.)

(9) PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for health care.

DATE AND SIGNATURE OF PRINCIPAL

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on _____ (Date) at _____ (City) _____ (State)

_____

(You sign here)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY TWO (2) QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.)

STATEMENT OF WITNESSES

(This document must be witnessed by two (2) qualified adult witnesses. None of the following may be used as a witness:

(1) A person you designate as your agent or alternate agent,

(2) A health care provider,

(3) An employee of a health care provider,

(4) The operator of a community care facility,

(5) An employee of an operator of a community care facility.

At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

Signature:_____ Residence Address:_____

Print Name:_____ _____

Date:_____ _____

Signature:_____ Residence Address:_____

Print Name:_____ _____

Date:_____ _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

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

Signature:_____
Signature:_____
Print Name:_____
Print Name:_____

Tennessee Code § 34-6-203

General Provisions:

A durable power of attorney for health care in the State of Tennessee must include the following notice and attestation and be signed by at least two witnesses, each of whom witnessed the signing of the instrument by the principal or the principal's acknowledges of the signing or of the instrument. There is no prescribed form.

None of the following may be used as a witness:

(1) a health care provider;

(2) an employee of a health care provider;

(3) the person named as the attorney in fact;

(4) the operator of a health care facility; or

(5) an employee of an operator of a health care facility.

At least one of the person's used as a witness shall not be one of the following:

(1) a relative of the principal by blood, marriage or adoption; or

(2) a person who would be entitled to any portion of the estate of the principal upon death of the principal under any will or codicil thereto of the principal existing at the time of execution of the durable power of attorney or by operation of law then existing.

FORMS

Required notice:

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document you should know these important facts.

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your

agent to make health care decisions for you if your agent: (1) authorizes anything that is illegal; or (2) acts contrary to your desires as stated in this document.

You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to: (1) authorize an autopsy; (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes; and (3) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask an attorney to explain it to you.

Required attestation:

I declare under penalty of perjury under the laws of Tennessee that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a health care institution nor an employee of an operator of a health care institution. At least one (1) of the witnesses must also have signed the following declaration: I further declare under penalty of perjury under the laws of Tennessee that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

The durable power of attorney for health care must be acknowledged before a notary public at any place within this state, the notary public certifying to the substance of the following:

State of Tennessee
County of _____

On this ____ day of _____, in the year _____, before me, _____ (insert name of notary), personally known to me (or provided to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he executed it. I declare under penalty of perjury that the

person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

NOTARY SEAL

_____

(Signature of Notary Public)

Texas Civil Practice and Remedies Code §§ 135.001–135.018

General Provisions

A durable power of attorney for health care in the State of Texas must be in substantially the same form as provided. It must be signed by the principal or another person in the principal's presence and at the principal's express direction.

A witness may not, at the time of execution, be:

(1) the agent;

(2) the principal's health or residential care provider or provider's employee

(3) the principal's spouse or heir;

(4) a person entitled to any part of the estate of the principal on the death of the principal under a will or deed in existence or by operation of law; or

(5) any other person who has any claim against the estate of the principal.

FORM

INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

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 in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has 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 may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority begins when your doctor certifies that you lack the capacity to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that 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. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years or age who has had the disabilities of minority removed. 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 has 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.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not 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 your agent or your health or residential care provider orally or in writing, or by your execution of a subsequent durable power of attorney for health care. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that you agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO OR MORE QUALIFIED WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

(1) the person you have designated as your agent;

(2) your health or residential care provider or an employee of your health or residential care provider;

(3) your spouse;

(4) your lawful heirs or beneficiaries named in your will or a deed; or

(5) creditors or persons who have a claim against you.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
DESIGNATION OF HEALTH CARE AGENT.

I, _____ (insert your name) appoint:

Name:_____
Address:_____
_____Phone_____
as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This durable power of attorney for health care takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:_____

_____

DESIGNATION OF ALTERNATE AGENT.

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. *First Alternate Agent*
Name:_____
Address:_____
_____ Phone_____

B. *Second Alternate Agent*
Name:_____
Address:_____
_____ Phone_____

The original of this document is kept at_____

_____

The following individuals or institutions have signed copies:
Name:_____
Address:_____
_____
Name:_____
Address:_____
_____

DURATION.

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney ends on the following date:

_____

PRIOR DESIGNATIONS REVOKED.

I revoke any prior durable power of attorney for health care.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT.

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this durable power of attorney for health care on ____ day of _____ 19__ at _____ (city and State)

_____

(Signature)

_____

(Print Name)

STATEMENT OF WITNESSES.

I declare under penalty of perjury that the principal has identified himself or herself to me, that the principal signed or acknowledged this durable power of attorney in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, that I am not the person appointed as agent by this document, and that I am not a provider of health or residential care, an employee of a provider of health or residential care, the operator of a community care facility, or an employee of an operator of a health care facility.

I declare that I am not related to the principal by blood, marriage, or adoption and that to the best of my knowledge I am not entitled to any part of the estate of the principal on the death of the principal under a will or by operation of law.

Witness Signature:_____

Print Name:_____ Date:_____

Address:_____

Witness Signature:_____

Print Name:_____ Date:_____

Address:_____

Vermont Statutes Title 14 § 3466

General Provisions

A durable power of attorney for health care in the State of Vermont shall be substantially in the form provided.

A person may not exercise the authority of agent while serving in one of the following capacities:

(1) the principal's health care provider;

(2) a nonrelative of the principal who is an employee of the principal's health care provider;

(3) the principal's residential care provider; or

(4) a nonrelative of the principal who is an employee of the principal's residential care provider.

The durable power of attorney for health care shall be signed by the principal or by some other person in the principal's presence and at the principal's express direction in the presence of at least two or more subscribing witnesses, neither of whom shall, at the time of execution, be the agent, the principal's health or residential care provider or the provider's employee, the principal's spouse, heir, a person entitled to any part of the estate of the principal upon the death of the principal under a will or deed in existence or by operation of law or any other person who has, at the time of execution, any claims against the estate of the principal.

FORM

INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

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 decision 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.

You may state in this document any treatment you do not desire 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. You may attach additional pages if you need more space to complete your statement.

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.

It is important that you discuss this document with your physician or other health care providers 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. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as 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.

You should inform the person you appoint that you want him or her to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who 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.

This document may not be changed or modified. If you want to make changes in the document you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable 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 VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO (2) OR MORE QUALIFIED WITNESSES WHO MUST BOTH BE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. THE FOLLOWING PERSONS MAY *NOT* ACT AS WITNESSES:

—the person you have designated as your agent;

—your health or residential care provider or one of their employees;

—your spouse;

—your lawful heirs or beneficiaries named in your will or a deed;

—creditors or persons who have a claim against you.

Vermont Statutes Title 14 § 3466. Durable power of attorney; form

The durable power of attorney shall be in substantially the following form:

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, hereby appoint _____ of _____ as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions.

(a) STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS REGARDING HEALTH CARE DECISIONS.

Here you may include any specific desires or limitations you deem appropriate, such as when or what life-sustaining measures should be withheld; directions whether to continue or discontinue artificial nutrition and hydration; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason.

_____

_____

_____

_____

_____

(attach additional pages as necessary)

(b) THE SUBJECT OF LIFE-SUSTAINING TREATMENT IS OF PARTICULAR IMPORTANCE. For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INCLUDE THE STATEMENT IN THE BLANK SPACE ABOVE: If I suffer a condition from which there is no reasonable prospect of regaining my ability to think and act for myself, I want only care directed to my comfort and dignity, and authorize my agent to decline all treatment (including artificial nutrition and hydration) the primary purpose of which is to prolong my life. If I suffer a condition from which there is no reasonable prospect of regaining my ability to think and act for myself, I want care directed to my comfort and dignity and also want artificial nutrition and hydration if needed, but authorize my agent to decline all other treatment the primary purpose of which is to prolong my life.

I want my life sustained by any reasonable medical measures, regardless of my condition.

In the event the person I appoint above is unable, unwilling or unavailable to act as my health care agent, I hereby appoint _____ of _____ as alternate agent.

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.

The original of this document will be kept at _____ and the following persons and institutions will have signed copies:

_____

In witness whereof, I have hereunto signed my name this ____ day of _____, 19__.

_____

Signature

I declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that the principal has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

Witness:_____ Address:_____

Witness:_____ Address:_____

Statement of ombudsman, hospital representative or other authorized person (to be signed only if the principal is in or is being admitted to a hospital, nursing home or residential care home):

I declare that I have personally explained the nature and effect of this durable power of attorney to the principal and that the principal understands the same.

Date:_____

Address:_____

Name:_____

West Virginia Code § 16 30A-18

General Provisions:

A medical power of attorney in the State of West Virginia must be substantially in the form provided. It may be signed by another person in the principal's presence at the principal's express direction. It must be signed in the presence of two or more witnesses at least 18 years of age and acknowledged before a notary public.

The following may not serve as a representative or successor representative:

(a) a treating health care principal;

(b) an employee of a treating health care principal;

(c) an operator of a health care facility serving the principal; or

(d) an employee of an operator of a health care facility not related to the principal.

Each witness must attest that he or she is not:

(1) the person who signed the Medical power of attorney on behalf of and at the direction of the principal;

(2) related to the principal by blood or marriage;

(3) entitled to any portion of the estate of the principal according to intestate succession of the state of the principal's domicile or under any will of the principal or any codicil;

(4) legally responsible for the costs of the principal's medical or other care;

(5) the attending physician; or

(6) the representative or any successor representative appointed pursuant to this article.

FORM

MEDICAL POWER OF ATTORNEY

Dated: _____, 19_____.

I, _____, (insert your name and address), hereby appoint _____ (insert the name, address, area code and telephone number of the person you wish to designate as your representative) as my representative to act on my behalf to give, withhold or withdraw informed consent to health care decisions in the event that I am not able to do so myself. If my representative is unable, unwilling or disqualified to serve, then I appoint _____ as my successor representative.

This appointment shall extend to (but not be limited to) decisions relating to medical treatment, surgical treatment, nursing care, medication, hospitalization, care and treatment in a nursing home or other facility, and home health care. The representative appointed by this document is specifically authorized to act on my behalf to consent to, refuse or withdraw any and all medical treatment or diagnostic procedures, if my representative determines that I, if able to do so, would consent to, refuse or withdraw such treatment or procedures. Such

authority shall include, but not be limited to, the withholding or withdrawal of life-prolonging intervention when in the opinion of two physicians who have examined me, one of whom is my attending physician, such life-prolonging intervention offers no medical hope of benefit.

I appoint this representative because I believe this person understands my wishes and values and will act to carry into effect the health care decisions that I would make if I were able to do so, and because I also believe that this person will act in my best interests when my wishes are unknown. It is my intent that my family, my physician and all legal authorities be bound by the decisions that are made by the representative appointed by this document, and it is my intent that these decisions should not be the subject of review by any health care provider, or administrative or judicial agency.

It is my intent that this document be legally binding and effective. In the event that the law does not recognize this document as legally binding and effective, it is my intent that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period when I am unable to make such decisions.

In exercising the authority under this medical power of attorney, my representative shall act consistently with my special directives or limitations as stated below.

SPECIAL DIRECTIVES OR LIMITATIONS ON THIS POWER: (If none, write "none."

_____

_____

_____

THIS MEDICAL POWER OF ATTORNEY SHALL BECOME EFFECTIVE ONLY UPON MY INCAPACITY TO GIVE, WITHHOLD OR WITHDRAW INFORMED CONSENT TO MY OWN MEDICAL CARE.

These directives shall supersede any directives made in any previously executed document concerning my health care.

X_____

Signature of Principal

I did not sign the principal's signature above. I am at least eighteen years of age and am not related to the principal by blood or marriage. I am not entitled to any portion of the estate of the principal according to the laws of intestate succession of the state of the principal's domicile or to the best of my knowledge under any will of the principal or codicil thereto, or legally responsible for the costs of the principal's medical or other care. I am not the principal's attending physician, nor am I the representative or successor representative of the principal.

WITNESS: DATE:

_____ _____

WITNESS: DATE:

_____ _____

STATE OF _____,

COUNTY OF _____, to-wit:

I, _____, a Notary Public of said County, do certify that _____, as principal, and _____ and _____, as witnesses, whose names are signed to the writing above bearing date on the ____ day of _____, 19__, have this day acknowledged the same before me.

Given under my hand the ____ day of _____, 19__.

My commission expires: _____.

_____

Wisconsin Statutes § 155.30

General Provisions:

A printed form of a power of attorney for a health care instrument that is sold or otherwise distributed for use by an individual in the State of Wisconsin who does not have the advice of legal counsel shall provide no authority other than the authority to make health care decisions on behalf of the principal and shall contain the notice provision below in not less than 10-point boldface type. A power of attorney for health care which does not follow the form must include the notice provision.

The health care agent can not be a health care provider for the individual, an employee of the health care provider for the individual, or an employee of a health care facility in which an individual is a patient or resides, or a spouse of any of these providers or employees, unless the health care provider, employee or spouse of the provider or employee is a relative of the individual.

No witness to the execution of the power of attorney for health care instrument may, at the time of the execution, be any of the following:

(a) related to the individual by blood, marriage or adoption;

(b) have knowledge that he or she is entitled to or has a claim on any portion of the principal's estate;

(c) directly financially responsible for the principal's health care;

(d) a health care provider who is serving the principal at the time of execution; or

(e) the principal's health care agent.

FORM

NOTICE TO PERSON MAKING THIS DOCUMENT

YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.

BECAUSE YOUR HEALTH CARE PROVIDERS IN SOME CASES HAVE NOT HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.

IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO

OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT AS YOU WISH. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES THE PERSON WHOM YOU SPECIFY BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU CHANGE YOUR MIND ABOUT WHETHER A PERSON SHOULD MAKE HEALTH CARE DECISIONS FOR YOU, OR ABOUT WHICH PERSON THAT SHOULD BE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING THE DOCUMENT OR DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, REVOKING IT IN A WRITTEN STATEMENT WHICH YOU SIGN AND DATE OR STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY THE PERSON YOU HAD SPECIFIED, YOUR HEALTH CARE PROVIDERS AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF THE PERSON YOU HAVE SPECIFIED IS YOUR SPOUSE AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND WHAT IT MEANS.

IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.

POWER OF ATTORNEY FOR HEALTH CARE

Instrument made this ____ day of _____ (month), ____ (year).

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I, _____ (name and address), being of sound mind, intend by this document to create a power of attorney for health care. My executing this power of attorney for health care is voluntary. I expect, despite the creation of this power of attorney for health care, to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For the purposes of this document, "health care decision" means an informed decision in the exercise of my right to accept, maintain, discontinue or refuse any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition.

DESIGNATION OF HEALTH CARE AGENT

If I am no longer able to make health care decisions for myself, due

to my incapacity, I hereby designate _____ _____ (name, address and telephone number) to be my health care agent for the purpose of making health care decisions on my behalf. If he or she is ever unable or unwilling to do so, I hereby designate _____ (name, address and telephone number) to be my alternate health care agent for the purpose of making health care decisions on my behalf. Neither the health care agent or the alternate health care agent whom I have designated is my health care provider, an employee of my health care provider or an employe of a health care facility in which I reside or am a patient or a spouse of any of those persons, or, if he or she is that health care provider or employe or spouse of that health care provider or employe, he or she is also my relative. For purposes of this document, "incapacity" exists if 2 physicians or a physician and a psychologist who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions. A copy of that statement, if made, must be attached to this document.

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent for all of my health care. I have discussed my desires thoroughly with my health care agent and believe that he or she understands my philosophy regarding the health care decisions I would make if I were so able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

My health care agent is instructed that if I am unable, due to my incapacity, to make a health care decision he or she shall make a health care decision for me, except that in exercising that authority given to him or her by this document my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care agent shall base his or her health care decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care agent shall base his or her health care decision on what he or she believes to be in my best interest.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for the mentally retarded, a state treatment facility or a treatment

facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or other drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES OR COMMUNITY-BASED RESIDENTIAL FACILITIES

My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

If I am diagnosed as mentally ill or developmentally disabled, my health care agent may not admit me to a nursing home or community-based residential facility for a purpose other than recuperative care or respite care.

If I am not diagnosed as mentally ill or developmentally disabled, and if I have checked "Yes" to the following, however, my health care agent may admit me for a purpose other than recuperative care or respite care to:

1. A nursing home—Yes _____ No _____

2. A community-based residential facility—Yes _____ No _____

If I have not checked either "Yes" or "No" to admission to a nursing home or community-based residential facility for a purpose other than recuperative care or respite care, my health care agent may only admit me for short-term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care agent may have nonorally ingested nutrition and hydration withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care agent may not have nonorally ingested nutrition and hydration withheld or withdrawn from me.

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw nonorally ingested nutrition and hydration—Yes _____ No _____

If I have not checked either "Yes" or "No" to withholding or withdrawing nonorally ingested nutrition and hydration, my health care agent may not have nonorally ingested nutrition and hydration withdrawn from me.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my health care agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

Health care decision if I am pregnant—Yes _____ No _____

If I have not checked either "Yes" or "No" to permitting my health care agent to make health care decisions for me if I am known to be pregnant, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS

In exercising authority under this document, my health care agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions or limitations that I wish to state (add more items if needed):

1)_____

2)_____

3)_____

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care agent has the authority to do all of the following:

(a) Request, review and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

(b) Execute on my behalf any documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

SIGNING DOCUMENTS, WAIVERS AND RELEASES

Where necessary to implement the health care decisions that my health care agent is authorized by this document to make, my health care agent has the authority to execute on my behalf any of the following:

(a) Documents titled or purporting to be a "Consent to Permit Treatment", "Refusal to Permit Treatment" or "Leaving Hospital Against Medical Advice".

(b) A waiver or release from liability required by a hospital or physician.

STATEMENT OF WITNESSES

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this power of attorney for health care is voluntary. I am at least 18 years of age and am not related to the principal by blood, marriage or adoption. I am not a health care provider who is serving the principal at this time. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness _____ (name, address, date)

Witness _____ (name, address, date)

STATEMENT OF HEALTH CARE AGENT

I understand that _____ (name of principal) has designated me to be his or her health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself. _____ (name of principal) has discussed his or her desires regarding health care decisions with me.

Signed _____ Address _____

STATEMENT OF ALTERNATE HEALTH CARE AGENT

I understand that _____ (name of principal) has designated me to be his or her health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself and if the person designated as health care agent is unable or unwilling to make those decisions _____ (name of principal) has discussed his or her desires regarding health care decisions with me.

Signed _____ Address _____

Notary Public

Wyoming Statutes § 3-5-202

General Provisions:

A durable power of attorney for health care in Wyoming has no provided form but requires:

(1) The date of its execution;

(2) Witnessing by one of the following methods:

(A) Signatures of at least two witnesses each of whom witnessed either the signing of the instrument by the principal or the principal's acknowledgement of a signature or of the instrument, each witness making the following declaration in substance:

"I declare under penalty of perjury by the laws of Wyoming that the person who signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not the treating health care provider, an employee of a treating health care provider, the operator of a community care facility, the operator of a residential care facility, nor an employee of an operator of a residential care facility." and

At least one (1) of the witnesses shall also have signed the following declaration:

"I further declare under penalty of perjury under the laws of Wyoming that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law." or

(B) The durable power of attorney is sworn to and acknowledged before a notary public.

The attorney-in-fact should not be the treating health care provider nor an employee of the treating health care provider, nor an operator of a community care facility or residential care facility unless they are a relative of the principal by blood, marriage or adoption.

A health care provider or employee of a health care provider shall not act as an attorney in fact to make health care decisions if the health care provider becomes the principal's treating health care provider. None of the following shall be used as a witness:

(A) A treating health care provider;

(B) An employee of a treating health care provider;

(C) The attorney in fact;

(D) The operator of a community care facility;

(E) An employee of an operator of a community care facility;

(F) The operator of a residential care facility;

(G) An employee of an operator of a residential care facility.

At least one (1) of the persons used as a witness shall be a person who is not one (1) of the following:

(A) A relative of the principal by blood, marriage, or adoption; or

(B) A person who would be entitled to any portion of the estate of the principal upon his or her death under any will or codicil thereto of the principal existing at the time of execution of the durable power of attorney or by operation of law then existing.

Other Publications by the Author

- **The Living Trust: A Cure for the Agony of Probate**
- **Lawsuit and Asset Protection Kit**
- **Estate Planning for the 1990s: A Practical Guide to Wills, Trusts, Probate and Death Taxes for Everyone**
- **How to Protect Your Assets, Perfectly Legally, from the Catastrophic Costs of Nursing-Home Care**
- **How to Deal With the IRS**
- **The Legal Forms Kit**
- **You and Your Will: A Complete Do-It-Yourself Manual**
- **How to Cut Your Mortgage in Half**
- **Facts about AIDS**
- **Teach Your Baby to Swim-** ***Video***

Revia Karl, a frail, 84-year-old woman is living her last years in a psychotic haze in an Inglewood, California hospital. So she doesn't know that her grandson ran through most of her $75,000 in life savings after a court appointed him her conservator. In Washington D.C., an attorney acting as conservator took $376,000 from an elderly man's estate. He later pleaded guilty to fraud. A Colorado woman, conservator for her ailing husband, spent $80,000 of his funds on her son's business.

- Stories reported in the Wall St. Journal

How can you protect yourself and your estate from such abuses?

How can you be certain that decisions about your health and your money will be made by someone you trust, and not by someone appointed by a court?

Now there's a solution...little-known but sure-proof...and extremely easy to implement.

This legal tool is called the durable power of attorney.

The function of a durable power of attorney is to eliminate the need for conservatorship or guardianship proceedings in a court of law should you ever become incapacitated and are unable to manage your own financial affairs or make your own health care decisions. Indeed, it's an ounce of prevention worth far more than the pound of cure the courts will provide after the fact.

This book provides many of the answers and actual forms and instructions to protect yourself against just such a possibility. There are common law and statutory forms of durable power of attorney and you'll be able to find a form that fits your desires and circumstances. The book uniquely addresses various jurisdictional requirements and provides state-specific forms and is thus applicable on a national level.

Homestead Publishing Company
23844 Hawthorne Blvd., Suite 200
Torrance, CA 90505
(310) 791-9975