POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT

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 may not have 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. 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 your agent 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 wish to change your power of attorney for health care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your agent, health care provider(s), and any other person(s) to whom you have given a copy. If your agent is your spouse or your domestic partner and your marriage is annulled or you are divorced or your domestic partnership is terminated after signing this document, the document is invalid.

You may also use this document to make or refuse to make an anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior record of gift that you may have made. You may revoke or change any anatomical gift that you make by this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document on file with your physician.

POWER OF ATTORNEY FOR HEALTH CARE

Document made this _____ of _____, _____.

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I, _____ residing at _____, _____, _____ _____ and born on _____ 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. Despite the creation of this power of attorney for health care, I expect 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 to accept, maintain, discontinue, or refuse any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition.

In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

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 _____ located at _____, _____, _____ _____ and reachable at _____ 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 _____ located at _____, _____, _____ _____ to be my alternate health care agent for the purpose of making health care decisions on my behalf. Neither my health care agent nor my alternate health care agent whom I have designated is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient or a spouse of any of those persons, unless he or she is also my relative. For purposes of this document, “incapacity” exists if two 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 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, if I need treatment, for all of my health care and treatment. 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 able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

If I am unable, due to my incapacity, to make a health care decision, my health care agent is instructed to make the health care decision for me, but 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 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 persons with mental retardation, 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 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.

My health care agent may admit me to a nursing home for a purpose other than recuperative care or respite care.

My health care agent may admit me to a community-based residential facility for a purpose other than recuperative care or respite care.

PROVISION OF FEEDING TUBE

My health care agent may have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

My health care agent may make health care decisions for me even if my 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):

_____

_____

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, oral 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.

(The principal and the witnesses all must sign the document at the same time.)

ANATOMICAL GIFTS

Upon my death, _____

SIGNATURE OF PRINCIPAL

I understand the contents of this document and the effect of granting powers to my agent. By signing this document, I revoke all previous power of attorney for health care documents.

_____ _____

Principal's Signature Date

_____

Principal's Name

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, am not related to the principal by blood, marriage, domestic partnership, or adoption, and am not directly financially responsible for the principal's health care. I am not a health care provider who is serving the principal at this time, an employee of the health care provider, other than a chaplain or a social worker, or an employee, other than a chaplain or a social worker, of an inpatient health care facility

in which the declarant is a patient. I am not the principal's health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

First Witness

Witness 1 Signature Date

_____

Witness 1 Name

_____

Witness 1 Address

_____ _____ _____

City State Zip Code

Second Witness

Witness 2 Signature Date

_____

Witness 2 Name

_____

Witness 2 Address

_____ _____ _____

City State Zip Code

STATEMENT OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT

I understand that _____ has designated me to be his or her health care agent or alternate health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself _____ has discussed his or her desires regarding health care decisions with me.

Agent's Signature Date

_____

Agent's Name

_____

Agent's Address

_____ _____ _____

City State Zip Code

Alternate Agent's Signature Date

Alternate Agent's Name

Alternate Agent's Address

City State Zip Code

Failure to execute a power of attorney for health care document under chapter 155 of the Wisconsin Statutes creates no presumption about the intent of any individual with regard to his or her health care decisions.

This power of attorney for health care is executed as provided in chapter 155 of the Wisconsin Statutes.

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GENERAL INSTRUCTIONS

WHAT IS A MEDICAL POWER OF ATTORNEY?

A Power of Attorney for Health Care allows you to name a health agent, someone who will make health decisions for you if you cannot. Your health care agent will ensure that your health care providers give you the care you wish to receive. You can also require that your health care agent communicate in any manner with you about any specific proposed health care.

WHEN IS IT NEEDED?

A Medical Power of Attorney or POAs are commonly used when someone wants the peace of mind that their health decisions will be made by someone they trust. The Health Care Agent steps into your shoes and can access your medical information and make decisions on your behalf.

You may need a Medical POA if you are:

- Over the age of 18 years old
- Military personnel being deployed overseas
- Traveling abroad for an extended time
- Diagnosed with a chronic condition or life threatening illness
- Growing wiser and older but concerned about your current health
- Married and want your spouse to have legal authority over property you own
- Participate in extreme sports or activities that put your health at risk
- Engaged in a high risk profession (i.e. firefighter or member of police force)

OTHER NAMES

People may call a Medical POA by: ·

- Advance Medical Directive·
- Durable Power of Attorney for Health Care·
- Health Care Advance Directive·
- Health Care Power of Attorney·
- Health Care Proxy·
- Medical Durable Power of Attorney·
- Power of Attorney for Health Care

WHAT SHOULD BE INCLUDED

A Medical Power of Attorney should generally address the following:

- Who do you trust to make healthcare decisions for you
- What kind of decisions can your health care agent make on your behalf
- When can your health care agent begin making medical decisions for you
- Why you prefer to continue or discontinue artificial life sustaining treatment

You can specify whether you health care agent can make these additional decisions on your behalf:

- **Mental Health Treatment**

· Admit you into an institution for mental diseases or state treatment facility
· Give consent to experimental mental health research or psychosurgery

- **Nursing Homes**

· Admit you into a nursing home
· Admit you into a community-based residential facility

- **Feeding Tubes**

- Withhold or withdraw a feeding tube

- **Pregnant Women**

- Health care agent may or may not make healthcare decisions for you if they know you are pregnant

- **Medical Records**

· Request, receive, and review all medical records
· Grant medical releases
· Consent to disclosure of info

- **Medical Treatment**

· Initiate or withhold a procedure
· Start or stop a medical service
· Modify medical care
· Employ and discharge healthcare personnel

- **Anatomical Gifts**

- Arrange or prohibit organ donations or donate your body