

POWER OF ATTORNEY FOR HEALTH CARE

EXPLANATION

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding anatomical gifts and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

You may name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions. You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, an agent may not have a controlling interest in or be an operator or employee of a residential long-term health-care institution at which you are receiving care.

If you do not have a qualifying condition (terminal illness/injury or permanent unconsciousness), your agent may make all health-care decisions for you except for decisions providing, withholding or withdrawing of a life sustaining procedure. Unless you limit the agent's authority, your agent will have the right to:

- (a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition unless it's a life-sustaining procedure or otherwise required by law.
- (b) Select or discharge health-care providers and health-care institutions;

If you have a qualifying condition, your agent may make all health-care decisions for you, including, but not limited to:

- (c) The decisions listed in (a) and (b).
- (d) Consent or refuse consent to life sustaining procedures, such as, but not limited to, cardiopulmonary resuscitation and orders not to resuscitate.
- (e) Direct the providing, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

You may also give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional instructions for other than end of life decisions.

You may also express an intention to donate your bodily organs and tissues following your death.



You may also designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. It is required that 2 other individuals sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that the person understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.



POWER OF ATTORNEY

A. DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me:

Agent's Full Name

Agent's Street Address

City

State

Zip Code

Agent's Home Number

Agent's Work Number

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

Alternate Agent's Full Name

Alternate Agent's Street Address

City

State

Zip Code

Alternate Agent's Home Number

Alternate Agent's Work Number

If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

Second Alternate Agent's Full Name

Second Alternate Agent's Street Address

City

State

Zip Code

Second Alternate Agent's Home Number

Second Alternate Agent's Work Number



B. AGENT'S AUTHORITY: I grant to my agent full authority to make decisions for me regarding my health care; provided that, in exercising this authority, my agent shall follow my desires as stated in this document or otherwise known to my agent. Accordingly, my agent is authorized as follows: (Initial next to each authority granted to your agent)

- _____ 1. To consent to, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function;
- _____ 2. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;
- _____ 3. To authorize my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service;
- _____ 4. To contract for any health care related service or facility on my behalf, without my agent incurring personal financial liability for such contracts;
- _____ 5. To hire and fire medical, social service, and other support personnel responsible for my care; and
- _____ 6. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) my death.

To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

C. OTHER MEDICAL INSTRUCTIONS: I direct that _____

D. WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my attending physician determines I lack the capacity to make my own health care decisions.

E. AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, health care decisions by my agent shall conform as closely as possible to what I would have done or intended under the circumstances. If my agent is unable to determine what I would have done or intended under the circumstances, my agent will make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

F. NOMINATION OF GUARDIAN: If a guardian of my person need to be appointed for me by a court, I nominate the following to be guardian in the order designated:



Guardian's Full Name

Guardian's Street Address

City State Zip Code

Guardian's Home Number **Guardian's Work Number**

Alternate Guardian's Full Name

Alternate Guardian's Street Address

City State Zip Code

Alternate Guardian's Home Number **Alternate Guardian's Work Number**

G. ANATOMICAL GIFTS AT DEATH: I hereby make the following anatomical gift(s) to take effect upon my death. I give: (Check one) my body any needed organs or parts the following organs or parts: _____ to: (Check one)

The following named physician, hospital, storage bank or other medical institution: _____

The following individual for treatment: _____

The hospital in which I die

The physician in attendance at my death, for the following purpose(s): (Check all that apply)

- any purpose authorized by law
- transplantation
- therapy
- research
- medical education

H. EFFECT OF COPY: A copy of this form has the same effect as the original. I understand the purpose and effect of this document.



Principal's Signature

Date

Principal's Name

Principal's Address

City

State

Zip Code



STATEMENT OF WITNESSES

SIGNED AND DECLARED by the above-named declarant as and for his/her written declaration under 16 Del.C. §§ 2502 and 2503, in our presence, who in his/her presence, at his/her request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state:

A. The Declarant is mentally competent.

B. That neither of us is prohibited by §2503 of Title 16 of the Delaware Code from being a witness.

Neither of us:

1. Is related to the declarant by blood, marriage or adoption;
2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the executing of the advance health care directive, is so entitled by operation of law then existing;
3. Has, at the time of the execution of the advance health care directive, a present or inchoate claim against any portion of the estate of the declarant;
4. Has a direct financial responsibility for the declarant's medical care;
5. Has a controlling interest in or is an operator or an employee of a health care institution in which the declarant is a patient or resident; or
6. Is under eighteen years of age.

C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses, _____ [Name], is at the time of the execution of the advance health care directive, a patient advocate or ombudsman designated by the Division of Services for Aging and Adults with Physical Disabilities or the Public Guardian.

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



NOTARY ACKNOWLEDGEMENT OF PRINCIPAL

State of Delaware)
) **(Seal)**
County of _____)

The foregoing instrument was acknowledged before me this ____ day of _____, 20____,
by the undersigned, _____, who is personally known to me or satisfactorily
proven to me to be the person whose name is subscribed to the within instrument.

Signature

Notary Public

My Commission Expires: _____

