District of Columbia

POWER OF ATTORNEY FOR MY HEALTH CARE

A Simple Health Care Advance Directive

This form combines the many different state legal requirements into a "universal" legal form that is intended to meet the basic requirements in most states. This form has space so you can add any special instructions or limitations you wish to include. But remember, this form is a basic Health Care Power of Attorney. It is not meant for a lengthy statement of your wishes and preferences. Remember, you should discuss your wishes and priorities directly with your agent and with others who are close to you.

INFORMATION ABOUT THE PRINCIPAL

Principal's Full Name

Principal's Street Address

City	State	Zip Code

Principal's Daytime Phone	**Principal's** Other Phone

Principal's Birthday	**Principal's** Email Address

WHO WILL BE YOUR HEALTH CARE AGENT?

Agent's Full Name

Agent's Street Address

City	State	Zip Code

Agent's Daytime Phone	**Agent's** Other Phone

Agent's Email Address

WHO WILL BE YOUR BACK-UP AGENT(S)?

If my first agent is unwilling or unable to act for any reason, then my next choice is:

Back-Up Agent's Full Name		
Back-Up Agent's Street Address		
City	State	Zip Code
Back-Up Agent's Daytime Phone	**Back-Up Agent's** Other Phone	
Back-Up Agent's Email Address		

If the first two agents are not willing or able to act for any reason, then my next choice is:

Second Back-Up Agent's Full Name		
Second Back-Up Agent's Street Address		
City	State	Zip Code
Second Back-Up Agent's Daytime Phone	**Second Back-Up Agent's** Other Phone	
Second Back-Up Agent's Email Address		

WHAT WILL YOUR AGENT'S POWERS BE?

My agent knows my goals and wishes based on our conversations and on any other guidance I may have written. My agent has full authority to make decisions for me about my health care according to my goals and wishes. If the choice I would make is unclear, then my agent will decide based on what he or she believes to be in my best interests. My agent's authority to interpret my wishes is intended to be as broad as possible, and includes the following authority: (Check all that apply)

☐ 1. To agree to, refuse, or withdraw consent to any type of medical care, treatment, surgical procedures, tests, or medications. **This includes decisions about using mechanical or other procedures that affect any bodily function, such as artificial respiration, artificially supplied nutrition and hydration (that is, tube feeding), cardiopulmonary resuscitation, or other forms of**

medical support, even if deciding to stop or withhold treatment could or would result in my death.
_____ (**Principal's initials**)

☐ 2. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose health information to others.

☐ 3. To authorize my admission to or discharge (even against medical advice) 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 for me, or apply for public or private health care benefits, with the understanding that my agent is not personally financially responsible for those contracts.

☐ 5. To hire and fire medical, social service, and other support personnel who are responsible for my care.

☐ 6. To authorize my participation in medical research related to my medical condition.

☐ 7. To agree to or refuse using any medication or procedure intended to relieve pain or discomfort, even though that use may lead to physical damage or dependence or hasten (but not intentionally cause) my death.

☐ 8. To decide about organ and tissue donations, autopsy, and the disposition of my remains as the law permits.

☐ 9. To take any other action necessary to do what I authorize here, including signing waivers or other documents, pursuing any dispute resolution process, or taking legal action in my name.

DO YOU HAVE SPECIAL INSTRUCTIONS OR LIMITATIONS FOR YOUR AGENT?

_____

WHEN WILL THIS POWER BE EFFECTIVE?

With this document, I intend to create this Power of Attorney for My Health Care, which shall take effect if I become incapable of making my own health-care decisions and shall continue during that incapacity.

OTHER PROVISIONS

1. Health care providers can rely on my agent**.** No one who relies in good faith on any representations by my agent or back-up agent will be liable to me, my estate, my heirs or assigns, for recognizing the agent's authority.

2. I cancel any previous power of attorney for health care that I may have signed.

3. I intend this power of attorney to be universal; it is valid in any jurisdiction in which it is presented.

4. I intend that copies of this document are as effective as the original.

5. My agent will not be entitled to compensation for services performed under this power of attorney, but he or she will be entitled to reimbursement for all reasonable expenses that result from carrying out any provision of this power of attorney.

SIGNATURE

I understand the contents of this document and the effect of granting powers to my agent.

_____

Principal's Signature

_____

Principal's Name

_____

Date

A STATEMENT BY YOUR WITNESSES

I declare that I personally know you — the person who signed this document — or I have adequate proof of your identity, and that you signed or acknowledged this *Power of Attorney for My Health Care* in front of me, and that you appear to be of sound mind and under no duress, fraud, or undue influence.

I am an adult and am **NOT** any of the following:

1. Appointed as your agent or back-up agent.
2. Related to you by blood, marriage, domestic partnership, or adoption, nor a spouse of any such person.
3. Your health care provider, including the owner or operator of a health, long-term care, or other residential or community care facility serving you.
4. An employee of your health care provider.
5. Financially responsible for your health care.
6. An employee of your life or health insurance provider.
7. A creditor of yours or entitled to any part of your estate under a will or codicil, trust, insurance policy, or by operation of intestate succession laws.
8. Entitled to benefit financially in any other way after you die.

First Witness

Witness Signature	Date	
Witness Name		
Witness Address		
City	State	Zip Code

Second Witness

Witness Signature	Date	
Witness Name		
Witness Address		
City	State	Zip Code

NOTARY ACKNOWLEDGEMENT OF PRINCIPAL

District of Columbia)
) **(Seal)**
County of _____)

The foregoing instrument was acknowledged before me this _____ day of **--(Please Select)--**, 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: _____

NOTARY ACKNOWLEDGEMENT OF WITNESSES

District of Columbia)
) **(Seal)**
County of _____)

The foregoing instrument was acknowledged before me this _____ day of **--(Please Select)--**, 20_____, by the undersigned witnesses, _____, and _____, who are 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: _____