# Proxy Directive

## (Durable Power of Attorney for Health Care) Designation of Health Care Representative

I understand that as a competent adult, I have the right to make decisions about my health care. There may come a time when I am unable, due to physical or mental incapacity, to make my own health care decisions. In these circumstances, those caring for me will need direction and they will turn to someone who knows my values and health care wishes. By writing this durable power of attorney for health care, I appoint a health care representative with the legal authority to make health care decisions on my behalf and to consult with my physician and others. I direct that this document become part of my permanent medical records.

**A) Choosing a Health Care Representative:**

I,_____, hereby designate_____,
of_____
_____,
**(home address and telephone number of health care representative)**
as my health care representative to make any and all health care decisions for me, including decisions to accept or refuse treatment, service or procedure used to diagnose or treat my physical or mental condition and decisions to provide, withhold or withdraw life-sustaining measures. I direct my representative to make decisions on my behalf in accordance with my wishes as stated in this document, or as otherwise known to him or her. In the event my wishes are not clear, my representative is authorized to make decisions in my best interests, based on what is known of my wishes.

This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions, as determined by the physician who has primary responsibility for my care, and any necessary confirming determinations.

**B) Alternate Representatives:** If the person I have designated above is unable, unwilling or unavailable to act as my health care representative, I hereby designate the following person(s) to act as my health care representative, in order of priority stated:

1. name_____ 2. name_____
address_____ address_____
city_____state_____ city_____state_____
telephone_____ telephone_____

**C) Specific Directions: Please initial the statement below which best expresses your wishes.**

____My health care representative is authorized to direct that artificially provided fluids and nutrition, much as by feeding tube or intravenous infusion, be withheld or withdrawn.

____My health care representative does not have this authority, and I direct that artificially provided fluids and nutrition be provided to preserve my life, to the extent medically appropriate.



*(If you have any additional specific instructions concerning your care you may use the space below or attach an additional statement.)*

_____
_____
_____
_____

***D) Copies:*** The original or a copy of this document has been given to my health care representative and to the following:

1. name_____

address_____

city_____state_____telephone_____
_

1. name_____

address_____

city_____state_____telephone_____
_

**E) Signature:** By writing this durable power of attorney for health care, I inform those who may become entrusted with my care of my health care wishes and intend to ease the burden of decisionmaking which this responsibility may impose. I have discussed the terms of this designation with my health care representative and he or she has willingly agreed to accept the responsibility for acting on my behalf in accordance with my wishes as expressed in this document. I understand the purpose and effect of this document and sign it knowingly, voluntarily and after careful deliberation.

**Signed this_____day of_____, 20____.**

signature_____

address_____

city_____state_____

**F) Witnesses:** I declare that the person who signed this document, or asked another to sign this document on his or her behalf, did so in my presence, that he or she is personally known to me, and that he or she appears to be of sound mind and free of duress or undue influence. I am 18 years of age or older, and am not designated by this or any other document as the person's health care representative, nor as an alternate health care representative.

1. witness_____ 2. witness_____
address_____ address_____
city_____state_____ city_____state____
signature_____ signature_____

date_____ date_____