NOTE: This form is being provided to you as a public service. The attached forms are provided “as is” and are not the substitute for the advice of an attorney. By providing these forms and information, Everplans is not providing legal advice to you. Consult an attorney if you need legal advice of any nature.

Read more and get more forms at Everplans’ Advance Directive page.
POWER OF ATTORNEY FOR HEALTH CARE

I, ___________________________ (print full name) , being of sound mind, do hereby designate ______________________________________ (print full name) as my agent with full power and authority to make health care decisions for me including, but not limited to, a Declaration Concerning Life-Sustaining Procedures in the event I am unable to or choose not to make these decisions for myself. This Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity or other condition that makes an express revocation of my agent impossible or impractical. I also grant my agent the authority to qualify me for all government entitlements including, but not limited to, Medicaid, Medicare, and Supplemental Social Security.

SIGNATURE ___________________________ PRINT NAME ___________________________

CITY, PARISH OF RESIDENCE ___________________________ STATE OF RESIDENCE ___________________________

The declarant has been personally known to me and I believe him or her to be of sound mind.

WITNESS 1 SIGNATURE ___________________________ WITNESS 1 PRINT NAME ___________________________

WITNESS 2 SIGNATURE ___________________________ WITNESS 2 PRINT NAME ___________________________

**Notarization of this form is optional.**

Sworn and subscribed before me,

this ___________ day of ______________________, _________.

______________________________
Notary Public

#____________________________
My commission expires _________________
DECLARATION CONCERNING LIFE-SUSTAINING PROCEDURES

Declaration made this _________ day of _________________________ (month, year).

I, __________________________________________________, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

If at any time I should have an incurable injury, disease or illness, or be in a continual profound comatose state with no reasonable chance of recovery, certified to be a terminal and irreversible condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedure would serve only to prolong artificially the dying process, I direct (initial one only):

___ That all life-sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.

___ That life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

Other directions - Add any personal instructions related to health care.

________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

I further direct 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.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this Declaration and I am emotionally and mentally competent to make this Declaration.

____________________________________ ____________________________________
SIGNATURE    PRINT NAME

____________________________________ ____________________________________
CITY, PARISH OF RESIDENCE  STATE OF RESIDENCE

The declarant has been personally known to me and I believe him or her to be of sound mind.

___________________________________  ____________________________________
WITNESS 1 SIGNATURE    WITNESS 1 PRINT NAME

___________________________________  ____________________________________
WITNESS 2 SIGNATURE    WITNESS 2 PRINT NAME