Life Protecting Power of Attorney for My Health Care Document

(Your Name)

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 yourfamily relationships. This poses a problem if you become physically or mentally unable to make decisionsabout your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want tomake 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 careagent. 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 changeyour 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 usethis 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 ofthis document on file with your physician or other primary care provider.

Power of Attorney for My Health Care

My name is: _____ Today's date _____/____/____
First Middle Last Month / Day / Year

I am completing this form in Wisconsin My birthdate _____/____/____
State Month / Day / Year

Part 1: My Health Care Agent

My Agent's name _____
First Middle Last

Relationship to me _____

Address _____
Number Street

_____

_____
City State ZIP Code

Daytime phone (_____) _____–_____

Other phone (_____) _____–_____

Email _____

Part 2: OPTIONAL Backups if your chosen agent or next choice is unwilling or unable to act for any reason

1st Backup Agent

_____
First Middle Last

Relationship to me _____

Address _____
Number Street

_____

_____
City State ZIP Code

Daytime phone (_____) _____–_____

Other phone (_____) _____–_____

Email _____

2nd Backup Agent

_____
First Middle Last

Relationship to me _____

Address _____
Number Street

_____

_____
City State ZIP Code

Daytime phone (_____) _____–_____

Other phone (_____) _____–_____

Email _____

Part 3: When AGENT's Authority Will Be Effective

This Power of Attorney will be effective only during the duration of my incapacity to make or communicate, health care decisions or the giving or refusing of consent to any matter which legally applies to this document and only limited by ***Part 5: Statement of Special Provisions, Directions and Limitations***. Under this document "incapacity" exists if in the opinion of my Agent, of my attending physician, and of a second health care provider as required by law who have personally examined me and express in a written statement, attached to this document, that I am unable to make and communicate the decisions.

I intend this power of attorney to be universal and valid in any jurisdiction in which it is presented. This power of attorney replaces any previous power of attorney that I signed.

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

Health care providers and others can rely on my Agent.

No one who relies on my Agent in good faith shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

Part 4: AGENT's Authority

Subject to the limitations of this document, I hereby grant to my Agent full **AUTHORITY** to make any health care decision(s) for me, including the giving or refusing of consent to any matter which legally applies to this document and only limited by **Part 5: *Statement of Special Provisions, Directions and Limitations***.

In exercising this **AUTHORITY**, my Agent shall make decisions that are consistent with this document.

I expressly eliminate any authority of any health care provider or any agent or employee of such provider to petition the court to remove or replace my Agent.

Whenever I refer to my Agent, I am referring to the person who is currently serving as my Agent, whether the originally designated Agent or one of the back-up agents.

Health care decisions include providing informed consent to accepting or refusing treatment, surgical procedures, tests or medications offered by the medical, nursing, and allied health professions. My Agent shall receive full, complete, and explicit information necessary for giving informed consent. Health care decisions also include my admission to or discharge from (even against medical advice) any hospital, nursing home, residential care, assisted-living, home care, palliative care or hospice care or similar facility or service. To carry out these duties, my Agent may determine where I will live, provide for meals, hire household employees, provide or contract for transportation, handle my mail, and arrange for recreation, entertainment and support services, provide for my safety and comfort and any other decision not involving my property or estate.

Part 5: INSTRUCTIONS, CONDITIONS AND RESTRICTIONS

Statement of Special Provisions, Directions and Limitations

I have discussed my principles and beliefs with my Agent. I trust my Agent to make health care and related decisions for me based on past, present and future discussions, subject only to the instructions, conditions and restrictions as expressed in this document.

A. This document is intended to confer legal immunity on my Agent unless my Agent does not act in accordance with the provisions, directions and limitations expressed in this document.

B. Decisions are to be made by my Agent. I reject any court or authority that refuses to recognize my Agent. If a court appoints a guardian of my person, I want this Health Care Power of Attorney to remain in effect and my Agent to serve as my guardian.

C. I direct my Agent to use the power and authority granted in this document to take any action to do what I authorize in this document, including signing waivers, pursuing any dispute resolution process or taking legal action in my name. I further direct that in any such action by my Agent, the decision(s) of my Agent under this document shall pre-empt any decision to not fund such efforts by a financial agent or court appointed guardian/conservator responsible for my property and estate.

D. I direct that my Agent have the same access to medical records and information that I would have and the right to disclose my health information and medical records.

E. I direct that my Agent shall authorize my admission to or discharge from (even against medical advice) any hospital, nursing home, residential care, assisted-living, home care, palliative care or hospice care or similar facility or service.

F. I direct that my Agent may contract for any health-related or other service or facility for me and apply for insurance, public or private benefits, with the understanding that my Agent is not personally financially responsible for those contracts.

G. Decisions made by my Agent shall be binding on my health care and other providers. I direct that my Agent may hire and fire health care, personal care, social service and other support staff who provide for my care.

H. I direct that my Agent shall be entitled to be reimbursed for all reasonable expenses that result from carrying out any provision of this document but shall not be entitled to compensation for services by my Agent.

I. I direct that my Agent request and consent to health care, treatment, services and procedures, which are appropriate to my condition and are beneficial for me, subject only to the limitations, provisions and directions expressed in this document. The meaning of the words “appropriate” and “beneficial,” for the purpose of this direction, are those which I have discussed with my Agent.

J. I direct that fluids and food (hydration and nutrition) be provided to me, by any means, unless death is inevitable and truly imminent from a cause other than the lack of nutrition and hydration so that the effort to sustain my life is futile or unless I am unable to assimilate fluids and food. The meanings of “imminent” and “futile” for the purposes of this document are those which I have discussed with my Agent.

K. I authorize my agent to withhold or withdraw consent, via an informed consent process, to health care treatment, services and procedures which are not appropriate to my condition and are not beneficial to me. The meaning of the words "not appropriate" and "not beneficial," for the purpose of this direction, are those which I have discussed with my Agent.

L. I direct that only my Agent will make the determination that a specific treatment will not be given during a future life-threatening event. Any such order shall specify the condition and treatment to be used or not used. For example: a) If cardiac function arrests, use or do not use external cardiac massage, defibrillation, etc.; or (b) If respiratory function arrests, use or do not use bag and mask ventilation, endo-tracheal intubation, ventilator, etc. To be legally valid, such specific order(s) shall be authorized by my Agent after an informed consent process. Broad orders of "Do Not Resuscitate," "No Code," "Do Not Intubate," and the like shall not be used.

M. I direct that only my Agent shall determine that a proposed therapy or treatment should not be performed because it is "medically futile." For purposes of this direction, "medically futile" means available data show it will not improve my medical condition. If that is not the case, it is not "medically futile."

N. I direct that my Agent request that I receive pain and symptom management when it is necessary to alleviate pain and other symptoms so that I can live to the limits of my potential and well-being. I further direct that my consciousness not be reduced more than is absolutely necessary.

O. I permit my Agent to enroll me in hospice only if there is no other way to obtain treatment and my death is inevitable and truly "imminent". The meaning of "imminent" for purposes of this document is what I have discussed with my Agent.

P. If I am receiving hospice/palliative care, I still direct that all of this Part 5 be followed and that my Agent decide whether to change providers or terminate my hospice/palliative care enrollment, at any time.

Q. I direct that my life not be shortened nor death hastened by withholding necessary treatments (e.g. no insulin for a diabetic); or by over sedating me or overdosing me to the point that my death is practically certain; or by causing my death by dehydration whether or not I am sedated or overdosed. The meaning of "necessary treatments" for purposes of this document is what I have discussed with my Agent.

R. I direct that my life not be ended by euthanasia or assisted suicide (also called Medical Aid in Dying).

S. If I should ask for euthanasia or an assisted death, I direct that my request be recognized as either a plea for symptom management or a plea for emotional, spiritual or psychological support.

T. I shall not be declared dead unless as a result of destruction my respiratory, circulatory, and nervous systems have irreversibly ceased all functioning. After my Agent is certain I have died, my Agent may decide about anatomical donations of my tissues, an autopsy or the disposition of my remains as the law permits.

U. I shall not be subjected to the procedure of the apnea test. Do not take organs for any reason.

PART 6: Signatures

(Sign and date in front of the two witnesses listed below.)

My signature: _____Date _____/____/_____
Mo Day Year

My printed name: _____
First Middle Last

Statement by Your Witnesses

I personally know the person who signed this document in front of me and believe the person to be of sound mind and at least 18 years of age and acting voluntarily under no duress, fraud or undue influence.

I am an adult and am: not appointed as your Agent or back-up Agent under this document; not related to you by blood, marriage, domestic partnership, or adoption, nor a spouse of any such person; not your health care provider, including the owner or operator of a health, long-term care, or other residential or community care facility serving you; not an employee of your health care provider; not financially responsible for your health care or personal care; not an employee or agent of your life or health insurance provider; not a creditor of yours; not entitled to any part of your estate under a will or codicil, trust, insurance policy, or by operation of intestate succession laws; and, not entitled to benefit financially in any other way after you die.

Witness 1	Witness 2
1st Witness - Printed Name	2nd Witness - Printed Name
_____	_____
First Middle Last	First Middle Last
Signature: _____	Signature: _____
Date: _____/_____/_____	Date: _____/_____/_____
Address _____	Address _____
Number Street	Number Street
_____	_____
_____	_____
City State ZIP Code	City State ZIP Code

Statement by Your Health Care or Backup Agent

I understand that _____
Printed First Middle Last Name
has designated me to be his/her health care agent or backup health care agent to make health care decisions for him/her while he/she is found to lack the capacity to make his/her own decisions. He/she has discussed his or her desires regarding health care decisions with me.

Agent's or Backup's Signature: _____

Agent's or Backup's Address : _____