Abington Jefferson Health®

# *DURABLE POWER OF ATTORNEY FOR HEALTH CARE*

# *And*

# *LIVING WILL*

## I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

### A. DESIGNATION OF HEALTH CARE AGENT.

I, _____, of _____
Name Street Address

_____, appoint
City, State and County

Healthcare Agent's name and relationship: _____

Address: _____

Phone: Home: _____ Cell: _____ Work: _____

E-mail Address:_____

as my Attorney-in-Fact (herein referred to as my "Healthcare Agent") to make health care and personal decisions for me if I become unable to make such decisions for myself, except to the extent I state otherwise in this document.

NOTICE: You should not appoint any of the following persons as your Healthcare Agent:

(1) Your physician or health care provider unless the person is your relative by blood, adoption or marriage;

(2) An employee of your physician or health care provider unless the person is your relative by blood, adoption or marriage;

(3) Your residential care provider; or

(4) An employee of your residential care provider unless the person is your relative.

**B. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.** By executing this document, I intend to create a Durable Power of Attorney for Health Care. This health care power of attorney shall take effect upon my incapacity or incompetency, and shall continue during such incapacity or incompetency.

**C. GENERAL STATEMENT OF AUTHORITY GRANTED.** Subject to any limitations in this document, I grant to my Healthcare Agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In making any decision, my Healthcare Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way.

In exercising this authority, my Healthcare Agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my Healthcare Agent. If my desires regarding a particular health care decision are not known to my Healthcare Agent, then my Healthcare Agent shall make the decision for me based upon what my Healthcare Agent believes to be in my best interests.

My Healthcare Agent's authority includes, but is not limited to, the power to authorize my admission to a medical, nursing, residential or similar facility and the power to authorize medical and surgical procedures. I authorize my Healthcare Agent, to the extent permitted by law, to make decisions about the withholding and withdrawal of life-sustaining treatment, including the withholding or withdrawal of artificially provided nutrition and hydration as well as to make decisions regarding do-not-resuscitate (DNR) orders and do-not-intubate (DNI) orders

**D. ANATOMICAL GIFTS.** ____ I authorize ____ I do not authorize (choose one) my Healthcare Agent to make an anatomical gift of all or part of my body in accordance with Pennsylvania law.

**E. DESIGNATION OF ALTERNATE HEALTHCARE AGENT.** If the person designated as my Healthcare Agent is not available or unable to act or refuses to act in accordance with my desires as stated in this document, I designate the following persons to serve as my Healthcare Agent to make health care decisions for me as authorized by this document, who serve in the following order:

First Alternative Healthcare Agent (name and relationship): _____

Address:_____

Phone: Home: _____ Cell: _____ Work: _____

E-mail Address:_____

Second Alternative Healthcare Agent (name and relationship):

_____

Address: _____

Phone: Home: _____ Cell: _____ Work: _____

E-mail Address:_____

## II. LIVING WILL

I, _____, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent and meet the statutory requirements for a living will to be effective in the Commonwealth of Pennsylvania. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

Provided that I have been deemed incompetent to make medical decisions for myself and provided that at least one of the following statements is true: (1) I am in a permanent state of unconsciousness; or (2) I am at the end-stage medical condition, then I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

(Please initial) I agree_____ I disagree_____

In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment:

I ( ) do ( ) do not want cardiac resuscitation.

I ( ) do ( ) do not want mechanical respiration.

I ( ) do ( ) do not want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).

I ( ) do ( ) do not want blood or blood products.

I ( ) do ( ) do not want any form of surgery, invasive procedures or diagnostic tests.

I ( ) do ( ) do not want kidney dialysis.

I ( ) do ( ) do not want antibiotics.

I ( ) do ( ) do not want chemotherapy.

I ( ) do ( ) do not want radiation treatment.

I ( ) do ( ) do not want to make anatomical gift of all or part of my body subject to the following limitations, if any:_____.

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

## III. GENERAL PROVISIONS

**A. HOLD HARMLESS.** All persons or entities who in good faith endeavor to carry out the terms and provisions of this document shall not be liable to me, my estate, my heirs or assigns for any damages or claims arising because of their action or inaction based on this document, and my estate shall defend and indemnify them.

**B. SEVERABILITY.** If any provision of this document is held to be invalid, such invalidity shall not affect the other provisions which can be given effect without the invalid provision, and to this end the directions in this document are severable.

**C. STATEMENT OF INTENTIONS.** It is my intent that this document be legally binding and effective. If the law does not recognize this document as legally binding and effective, it is my intent that this document be taken as a formal statement of my desire concerning the method by which any health care decisions should be made on my behalf during any period in which I am unable to make such decisions.

I have read and understand the contents of this document and the effect of this grant of powers to my Healthcare Agent. I am mentally competent to make this declaration.

Signed on _____ day of _____, _____.

Signature: _____

Name: _____

Address: _____

County: _____

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## STATEMENT OF WITNESSES

I declare that the person who signed or acknowledged this document has (1) identified himself or herself to me, (2) signed or acknowledged this document in my presence, (3) appears to be of sound mind, and under no duress, fraud or undue influence. I am not the person appointed as Healthcare Agent or Alternate Healthcare Agent by this document, nor am I the operator of a community care facility, or an employee of an operator of a health care facility.

I further declare that I am not related to him/her by blood, marriage, or adoption, and to the best of my knowledge, I am not a creditor of him/her or entitled to any part of the estate of him/her under a will now existing or by operation of law. Each of us is at least 18 years of age.

Witness Signature: _____

Name: _____

Address: _____

_____

_____

Witness Signature: _____

Name: _____

Address: _____

_____

_____