



## DECLARATION

### Durable Power of Attorney for Health Care (My appointment of a representative)

- If I should be incompetent and in a terminal condition or in a state of persistent unconsciousness, I want to designate another person as my representative to make the types of decisions checked below. All decisions should be made exactly as I would make them if I were capable. My representative is authorized to:
- Authorize my admission to a medical, nursing, residential or similar facility and enter into agreement for my care.
  - Authorize medical and surgical procedures.
  - Authorize withholding or withdrawing life-sustaining treatment.
  - Make all other medical treatment decisions.
- I do not want to designate another person as my representative if I should be incompetent and in a terminal condition or in a state of persistent unconsciousness.

**PLEASE NOTE:** The Power of Attorney for Health Care has the authority to make organ donation decisions.

Name, address and phone number of representative (if applicable): \_\_\_\_\_  
\_\_\_\_\_

Name, address and phone number of substitute representative (if representative designated above is unable to serve): \_\_\_\_\_  
\_\_\_\_\_

I made this declaration of the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Declarant's signature: \_\_\_\_\_

Declarant's address: \_\_\_\_\_

Declarant's phone: \_\_\_\_\_

The declarant or the person on behalf of and at the direction of the declarant knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness's signature: \_\_\_\_\_

Witness's signature: \_\_\_\_\_

Witness's address: \_\_\_\_\_

Witness's address: \_\_\_\_\_

Witness's phone: \_\_\_\_\_

Witness's phone: \_\_\_\_\_