POWER OF ATTORNEY FOR HEALTH CARE

Name: ____

Date of Birth: ____

Address: ____

Telephone: ____

I intend by this document to create a Power of Attorney for Health Care. My executing this power of attorney is voluntary. I expect to be fully informed about and allowed to participate in health care decisions for myself as long as I have the capacity to do so. For the purposes of this document, health care decision means an informed decision to accept, maintain, discontinue, or refuse any medical care.

Copies of this document have been given to:

1. ____

2. ____

3. ____

4. ____

5.____

If a new document is created, all previous copies should be replaced with a copy of the new one.

Revised 05/17/07

Power of Attorney for Health Care Document

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 your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make 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 care agent. 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 change your 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, your health care providers and any other person to whom you haven given a copy. If your agent is your spouse and your marriage is annulled or you are divorced 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 use this document to make or refuse to make an anatomical gift, this document revokes any prior document of gift 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 you keep the original of this document on file with your physician.

Part I – Appointing a Health Care Agent

If I am no longer able to make health care decisions for myself, this document names the person I choose as my agent to make these choices for me. This person will make my health care decisions if I am determined to be incapable to make health care decisions as defined by state law.

For the purpose of this document, 'incapacity' exists if two physicians or a physician and a psychologist have personally examined me and signed a statement that specifically expresses their opinion that I am unable to receive and evaluate information effectively or to communicate decisions. A copy of that statement must be attached to this document. If I am unable, due to my incapacity, to make health care decisions, my health care agent is instructed to make health care decisions for me, but my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes.

Note: When selecting someone to be your health care agent, choose someone who knows you well, who you trust, who is willing to respect your views and values, agrees to carry out your wishes, and is able to make difficult decisions in stressful situations. Take time to discuss this document and your views with the person you pick to be your health care agent and give him or her a copy of this document.

Your health care agent must be at least 18 years of age and should not be your health care provider, an employee of that health care provider, an employee of a health care facility in which you are a patient or resident, or a spouse of any of those providers or employees, unless the health care provider, employee or spouse of the provider or employee, is your relative.

The person I choose as my health care agent is:

Name: ___________________________________ Relationship: _____________________________

Address: ____

Phone numbers: Home _____________________Cell____________________Work_____________

If this health care agent is unavailable to make these choices for me, then my next choice for a health care agent is:

Name: ___________________________________ Relationship: _____________________________

Address: ____

Phone numbers: Home _____________________Cell_____________________Work____________

Part II – General authority of the Health Care Agent

Subject to any limitations in this document, my health care agent has the authority to request and review all information, oral and written, regarding my physical and mental health. This includes signing consent forms to release any medical information to other parties. I will discuss my desires with my health care agent and believe he or she is willing to carry them out.

Note: Check the box by your answer in each section. If you do not mark a box in a section and make no clear choice, Wisconsin law states that your choice is considered to be "No".

1. Admission to a nursing home or community based residential facility (CBRF):

My health care agent has authority to allow admission to a facility to receive long term nursing care if necessary. (Note: A health care agent automatically has authority to allow admission to a facility for short term stays.)

☐ Yes ☐ No Nursing Home

☐ Yes ☐ No CBRF/Group Home

2. Provision of a feeding tube:

My health care agent has authority to have a feeding tube or I.V. hydration withheld or withdrawn from me, unless my physician has advised that in his or her professional judgment this will cause me pain or will reduce my comfort.

☐ Yes ☐ No

3. Making decisions if I am pregnant:
My health care agent has authority to make decisions for me if I am pregnant.

☐ Yes ☐ No

Limitations on Mental Health Treatment

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for the mentally retarded or a state treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

Part III – Statement of specific Desires, Special Provisions or Limitations (optional)

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Donation of My Organs or Tissue:

☐ I wish to donate only these organs or tissues_____________________________________.

☐ I wish to donate any organs or tissue.

☐ I do not want to donate any organ or tissue.

Note: Donating your body to medical science needs to be arranged ahead of time.

Part IV – Making the Document Legal

This document must be signed and dated in the presence of two witnesses with both witnesses signing at the same time.

I am thinking clearly and agree with everything that is written in this document and have made this document willingly.

____ ________________________
My signature Date

Statement of Witnesses:

I know the principal (the person executing this document) personally and believe him/her to be of sound mind and at least 18 years of age. I personally witnessed him/her sign this document and believe he/she did so voluntarily.

By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not the Principal's health care agent.
- Not related to the principal by blood, marriage, or adoption.
- Not directly financially responsible for the principal's health care.
- Not a health care provider directly serving the principal at this time.
- Not an employee (other than social worker or chaplain) of a health care provider directly serving the principal at this time.
- Not aware that I am entitled to or have a claim against the principal's estate.

Witness #1: Date______________

____
Signature

____
Print Name

____
Address

Witness #2: Date______________

____
Signature

____
Print Name

____
Address