PART 1

POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me:

Name of Agent: _____

Address: _____

_____

Telephone: _____

If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

Name of Alternate Agent: _____

Address: _____

_____

Telephone: _____

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

Name of 2nd Alternate Agent: _____

Address: _____

_____

Telephone: _____

(2) AGENT'S AUTHORITY: My agent is authorized to obtain and review medical records, reports and information about me and to make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition, hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

(*Attach additional sheets as necessary*)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary care practitioner and one other qualified health-care professional determine that I am unable to make my own health-care decisions. If I initial this box [ ], my agent's authority to make health-care decisions for me takes effect immediately.

(4) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in PART 2 of this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in

accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may cross out any wording you do not want.

(6) END-OF-LIFE DECISIONS: If I am unable to make or communicate decisions regarding my health care, and IF (i) I have an incurable or irreversible condition that will result in my death within a relatively short time, OR (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, OR (iii) the likely risks and burdens of treatment would outweigh the expected benefits, THEN I direct that my health-care practitioners and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have initialed below in one of the following three boxes:

[ ] I CHOOSE NOT To Prolong Life

I do not want my life to be prolonged.

[ ] I CHOOSE To Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

[ ] I CHOOSE To Let My Agent Decide

My agent under my power of attorney for health care may make life-sustaining treatment decisions for me.

(7) ARTIFICIAL NUTRITION AND HYDRATION: If I have chosen above NOT to prolong life, I also specify by marking my initials below:

[ ] I DO NOT want artificial nutrition OR

[ ] I DO want artificial nutrition.

[ ] I DO NOT want artificial hydration unless required for my comfort OR

[ ] I DO want artificial hydration.

(8) RELIEF FROM PAIN: Regardless of the choices I have made in this form and except as I state in the following space, I direct that the best medical care possible to keep me clean, comfortable and free of pain or discomfort be provided at all times so that my dignity is maintained, even if this care hastens my death:

(9) ANATOMICAL GIFT DESIGNATION: Upon my death I specify as marked below whether I choose to make an anatomical gift of all or some of my organs or tissue:

[ ] I CHOOSE to make an anatomical gift of all of my organs or tissue to be determined by medical suitability at the time of death, and artificial support may be maintained long enough for organs to be removed.

[ ] I CHOOSE to make a partial anatomical gift of some of my organs and tissue as specified below, and artificial support may be maintained long enough for organs to be removed.

[ ] I REFUSE to make an anatomical gift of any of my organs or tissue.

[ ] I CHOOSE to let my agent decide.

(10) OTHER WISHES: (If you wish to write your own instructions, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(Add additional sheets if needed.)

PART 3

PRIMARY CARE PRACTITIONER

(11) I designate the following as my primary care practitioner:

Name of Primary Care Practitioner: _____
Address: _____
_____
Telephone: _____

If the primary care practitioner I have designated above is not willing, able or reasonably available to act as my primary care practitioner, I designate the following as my primary care practitioner:

Name of Primary Care Practitioner: _____
Address: _____
_____
Telephone: _____

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) REVOCATION: I understand that I may revoke this OPTIONAL ADVANCE HEALTH-CARE DIRECTIVE at any time, and that if I revoke it, I should promptly notify my supervising health-care practitioner and any health-care institution where I am receiving care and any others to whom I have given copies of this power of attorney. I understand that I may revoke the designation of an agent either by a signed writing or by personally informing the supervising health-care practitioner.

(14) SIGNATURES: Sign and date the form here:

_____
Signature of Principal

Print Name: _____
Address: _____
_____

(Optional) SIGNATURES OF WITNESSES:

_____
Witness 1 Signature

Print Name: _____
Address: _____
_____
_____

_____
Witness 2 Signature

Print Name: _____
Address: _____
_____
_____