Durable Power of Attorney for Health Care

This document is intended to create a Durable Power of Attorney for Health Care. Please fill in the blanks as appropriate.

1. Designation of Health Care Agent

I, _____, being of sound mind, hereby designate _____ as my health care agent (attorney-in-fact) to make health care decisions for me if I am unable to do so.

Address of Agent: _____

Telephone Number of Agent: _____

2. General Statement of Authority Granted

I trust my agent to make any and all health care decisions for me, including decisions to withhold or withdraw life-sustaining procedures, subject to any limitations I state below.

3. Statement of Desires, Special Provisions, and Limitations

(You may state any specific instructions or leave this section blank.)

_____ _____

_____

4. Effective Date

This durable power of attorney for health care becomes effective upon a determination by my attending physician that I am unable to make my own health care decisions.

5. Revocation

I understand that I may revoke this document at any time.

Date: _____

Signature: _____

Printed Name: _____

Witnesses

Witness #1: _____ Date: _____

Witness #2: _____ Date: _____

This document is provided as a sample. Please consult with a qualified attorney or health care professional regarding your specific needs and applicable laws in your jurisdiction.