

PART I – DURABLE HEALTH CARE POWER OF ATTORNEY

I, _____, of _____ County, Pennsylvania, appoint the person named below to be my agent to make health and personal care decisions for me **when and only when I lack sufficient capacity to make or communicate a choice regarding a health of personal care decision as verified by my attending physician.** My agent may not delegate the authority to make decisions. My agent has all of the following powers (subject to the Healthcare Treatment instructions that follow in Part II):

1. To authorize, withhold or withdraw medical care and surgical procedures;
2. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines or veins;
3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care, including hospice care;
4. To have full access to my medical and hospital records and all information regarding my physical or mental health;
5. To hire and fire medical, social service and other support personnel responsible for my care;
6. To take any legal action necessary to do what I have directed.

I appoint *[name,address,phone]* _____
to be my agent. If he/she is not available, I appoint *[name,address,phone]* _____
_____ to be my agent.

PART II – HEALTHCARE TREATMENT INSTRUCTIONS (LIVING WILL)

The following healthcare treatment instructions exercise my right to make decisions concerning my health care. These instructions are intended to provide clear and convincing evidence of my wishes to be following when I lack the capacity to make or communicate my treatment decisions:

TERMINAL ILLNESS OR PERMANENT UNCONSCIOUSNESS: If I suffer from a terminal condition or a state of permanent unconsciousness such as a permanent coma or persistent vegetative state and there is no realistic hope of significant recovery, all of the following apply:

1. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming;
2. I direct that all life prolonging procedures be withheld or withdrawn;
3. I specifically do not want any of the following as life prolonging procedures: heart-lung resuscitation (CPR), mechanical ventilator (breathing machine), dialysis (kidney machine), surgery, chemotherapy, radiation treatment antibiotics.

On behalf of myself, my executors and heirs, I hold my agents and my health care providers harmless and release and indemnify them against any claim for recognizing my agents' authority or for following my treatment instructions in good faith. Having carefully read this document, I have signed it this ____ day of _____, 200__, revoking all previous health care powers of attorney and medical treatment instructions.

[name]

WITNESS: _____

WITNESS: _____

On this ____ day of _____, 200__, before me personally appeared the aforesaid declarant, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed. IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of _____, Commonwealth of Pennsylvania, the day and year first above written.

Notary Public

My Commission Expires:

(SEAL)