DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Name_____ Date of Birth _____

Take a copy of this document with you whenever you go to the hospital.

This is a **Durable Power of Attorney for my Healthcare Decisions** and the authority of my agent when in effect shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive. This document revokes any prior Durable Power of Attorney for Healthcare Decisions.

1. Liability and Compensation: My agent(s) listed below may not appoint anyone else to make decisions for me. I and my estate hold my agent harmless and protect them against any claim based upon following this Durable Power of Attorney for Health Care decisions or for honoring my Healthcare Advance Directives. Any costs or reasonable expenses as a result of carrying out any provision should be paid from my own resources and my agent shall not be entitled to compensation for services performed under this Durable Power of Attorney.

2. Effective: This Durable Power of Attorney is effective when two physicians decide and certify that I am incapacitated and unable to make and communicate a health care decision**. *If you want ONE physician, instead of TWO, to decide whether you are incapacitated, write your initials here:_____.** RSMo 404.825

3. Agent Powers: I grant my agent full power to make all decisions for me about my health care, including the power to direct the withholding or withdrawal of life-prolonging treatment. In exercising this power, I expect my agent to be guided by my direction as stated in my Health Care Directives.

*If you do not wish to name an agent to make healthcare decisions for you, write your initials here*_____ .

I, (Print)_____, Date of Birth_____, willfully and voluntarily appoint as my agent:

(Name)_____ (Address)_____
(City)_____(State)_____ (Zip)_____ (Phone/email)_____

If _____*is unwilling or unable to act as my agent*, I then appoint

(Print Name)_____ (Address)_____
(City)_____(State)_____(Zip)_____ (Phone/email)_____

IN TESTIMONY WHEREOF, I have hereunto set my hand this _____day of _____20_____.

Signature:_____

NOTARIZATION:

On this _____ day of _____, 20_____, personally appeared before me the person signing, known by me to the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the county of _____, State of Missouri

_____ _____
Notary Public My Commission Expires

HEALTH CARE TREATMENT ADVANCE DIRECTIVE

Name_____ **Date of Birth** _____

This Health Care Treatment Advance Directive is to let everyone who cares for me know what health care measures I want when I cannot let others know what I want. If at any time I should have an incurable injury, disease, or illness certified by two physicians, considered to be a terminal condition, and that my death will occur whether or not life-sustaining procedures are utilized, then I direct such procedures be withheld or withdrawn. I understand that those measures may only artificially prolong the dying process. When I am unable to participate in making decisions regarding medical treatment, then I direct such procedures be withheld or withdrawn. It is my wish that I be permitted to die naturally.

However, if my physician believes a life-prolonging procedure might lead to a significant recovery, I direct my physician to try the treatment for a reasonable period of time. If it does not improve my condition, I direct the treatment be withdrawn even if it shortens my life. I always expect to be given care and treatment for pain or discomfort even when such care might affect my appetite, affect my breathing, or be habit-forming.

In the absence of my ability to give directions, it is my intention this Advance Directive be honored by my family, caregivers and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequence of such refusal.

If l am persistently unconscious (such as a persistent vegetative state with no reasonable hope of recovery) or there is no reasonable expectation of my recovery from a terminal illness or condition, I direct all of the following life-prolonging procedures be withheld or withdrawn: **(Please X or initial what you want withheld/withdrawn)**

- ☐ Surgery
- ☐ Heart-lung resuscitation (CPR)
- ☐ Antibiotics (drugs that stop infection)
- ☐ Dialysis (machines that operate my kidney)
- ☐ Mechanical ventilator (respirator)
- ☐ Chemotherapy (cancer treatment)
- ☐ Radiation therapy (cancer treatment)
- ☐ Artificially supplied nutrition and hydration (including tube feeding of food and water)
- ☐ All other "life-prolonging" medical or surgical procedures which are merely intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury.

I revoke any Living Wills or similar directions having the effect of a Living Will/Advance Directive which I may have executed prior to the date of this document. This document is executed pursuant to the laws of the State of Missouri,§§ 459.010 to 459.055, RSMo. This document is intended to also be valid in any other jurisdiction in which it is presented. The provisions of this document are severable, so the invalidity of one or more provisions shall not affect the validity of any others.

Please ask two (2) persons to witness your signature that are not related to you or financially connected to you or your estate.

Signature: _____ Print Name: _____ Date:_____

Witness: _____ Date:_____ Witness: _____ Date:_____

Witness phone/email:_____ Witness phone/email:_____