DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

DECISION TO NAME SOMEONE TO SPEAK FOR ME

I, (your name) _____ (date of birth) _____ , appoint the following person(s) to make healthcare decisions for me when I am unable to make or communicate my own wishes:

Agent may not be the treating healthcare provider, an employee of the treating healthcare provider, or an employee, owner, director or officer of a facility, unless that person is a relative or is bound to you by common vows to a religious life.

PLEASE PRINT:

Name of Agent:_____ _____ _____
Telephone Telephone

Agent's address: _____City_____State/Zip _____

Name of First Alternate Agent: _____ _____ _____
Telephone Telephone

Agent's address: _____City_____State/Zip _____

Name of Second Alternate Agent: _____ _____ _____
Telephone Telephone

Agent's address: _____City_____State/Zip _____

This power of attorney for healthcare decisions shall become effective when I am unable to make decisions or unable to communicate my wishes regarding healthcare. This power of attorney for healthcare decisions shall not be affected by my subsequent disability or incapacity. Any durable power of attorney for healthcare decisions I have previously made is hereby revoked.

AUTHORITY GRANTED

My healthcare agent may:

1. Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition;
2. Make all arrangements for me at any hospital, treatment facility, hospice, nursing home or similar institution;
3. Employ or discharge healthcare personnel including physicians, psychiatrists, dentists, nurses, therapists or other persons who provide treatment for me;
4. Request, receive and review any information, spoken or written, regarding my personal affairs or physical or mental health including medical and hospital records, and execute any releases or other documents that may be required in order to obtain such information; and
5. Make decisions about organ and tissue donations, autopsy and the disposition of my body.

My agent shall authorize consent for the following special instructions:

__ I wish to be a donor for organs and tissues.

I have attached information about treatment choices I wish to have honored by my agent. ___ page(s) attached.

LIMITATIONS ON AUTHORITY GRANTED

My healthcare agent may not:

1. Exceed the powers set out in writing in this document; *or*
2. Revoke any existing Living Will Declaration I may have.

X _____
signature date

Notary Public: Notary Seal:

STATE OF _____COUNTY OF _____

This instrument was acknowledged before me this _____ day of _____ (month, year)

Signature of Notary_____

or

Witnesses: (witnesses may not be the agent or a relative, or beneficiary of the principal)

X _____ Date: _____
(Signature)

X _____ Date: _____
(Signature)

This document is based on Kansas Statutes Annotated, (58-625 through 632)

LIVING WILL DECLARATION

Kansas Natural Death Act

I, _____, being of sound mind, willfully and voluntarily making known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any
medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this decision. Any Living Will declaration I have previously made is hereby revoked.

Declarations made this _____ (day) of _____ (month, year)

Signature:

X _____ Date of Birth _____

Address: _____
street **city** **state** **zip**

This document must be witnessed by two individuals *or* acknowledged by a notary public.

Notary Public: Notary Seal:

STATE OF _____ COUNTY OF _____

This instrument was acknowledged before me this _____ day of _____ (month, year)

Signature of Notary _____

or

Witnesses:

The declarant has been personally known to me and I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly responsible for declarant's medical care.

Name: _____ Name: _____

Address: _____ Address: _____

City, State, Zip: _____ City, State, Zip: _____

This document is based on Kansas Statute 65-28,101 et seq. as amended.

DNR
DO-NOT-RESUSCITATE DIRECTIVE

K.S.A. 65-4941, ET. SEQ.

DECISION TO LIMIT EMERGENCY MEDICAL CARE

I, (Your name) _____, request that effective today, emergency care for me will be limited as described below.

If my heart stops beating or if I stop breathing, no medical procedures to restart breathing or heart functioning will be instituted. No resuscitation will be attempted.

- I understand that the procedure I am refusing, known as cardiopulmonary resuscitation, (CPR), includes chest compressions, assisted ventilations, intubation, defibrillation, administration of cardiotonic medications and other related medical procedures.
- I do not intend for this decision to prevent me from obtaining other medical care, especially comfort measures and pain medication.
- I understand I may revoke this directive at any time.
- I give permission for this information to be given to emergency care providers, doctors, nurses or other health care personnel.
- This DNR directive shall remain in effect while I am admitted at a medical care facility or care home as well as during transport to or from a home or facility.

X _____ _____

(Signature) (Date)

X _____ _____

(Witness Signature) (Date)

Attending Physician Order: I have discussed the use of cardiopulmonary resuscitation with this patient and recognize the patient's decision to refuse CPR.

- In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation shall be attempted. **DNR**

X _____ _____

(Attending Physician's Signature) (Date)

_____ _____

(Address) (Facility, Clinic or Hospital Name)

Revocation: I hereby withdraw the above DNR directive.

X _____ _____

(Signature) (Date)