**MEDICAL POWER OF ATTORNEY**

**IMPORTANT INFORMATION**

IT IS IMPORTANT THAT YOU REVIEW THE FOLLOWING INFORMATION BEFORE YOU SIGN THIS DOCUMENT. READ THE INFORMATION CAREFULLY AND SEEK GUIDANCE FROM A HEALTHCARE PROFESSIONAL OR ATTORNEY IF YOU DO NOT UNDERSTAND ANY OF THE TERMS.

By signing this document, you are giving authority to the person you are designating as your agent to make medical decisions on your behalf. Medical decisions can include any medical service, treatment, medical procedure, diagnosis or treat both mental and physical conditions. Your agent will be able to act with the same authority you would have if you were able to act for yourself and will have the authority to consent, refuse to consent to medical treatment including decisions about withdrawing or withholding life-sustaining treatment. It is, therefore, important that you know and trust your agent and that your agent is aware of your preferences for health care treatment.

Even after you sign this document, you will still be able to make your health care decisions assuming you are still considered mentally competent. Your agent cannot act on your behalf until your physician has determined that you are no longer physically or mentally able to make medical decisions.

The person you choose as your agent must be at least eighteen years old and someone that you trust with your health care. Your agent is not liable for any decisions they make on your behalf, as long as those decisions were made in good faith. You should make sure that you have chosen agent wants to take on the role as agent. Discuss your medical preferences with your agent so they are aware of your wishes. Review this document with your agent so they are aware of their role. You also may choose a back-up agent in case your other agent is unavailable to act. Your back-up agent should also be over 18 and aware of your preferences.

You may revoke this document at any time while you are still competent to do so. You may revoke it by telling your medical provider and your agent that you are revoking the document or you may provide them a written revocation. If you execute another power of attorney later, that will have the effect of revoking this one.

In order for this document to be valid, it must be signed in the presence of a notary or two witnesses. If you choose to have two witnesses sign, they must be at least 18, competent and independent and not your agent or related to your agent.

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**APPOINTMENT OF HEALTH CARE AGENT**

I, [PRINCIPAL NAME], of [PRINCIPAL STREET], City of [PRINCIPAL CITY], State of [PRINCIPAL STATE] (HEREINAFTER known as the “Principal”) hereby appoint,

[AGENT NAME] of [AGENT STREET], City of [AGENT CITY], State of [AGENT CITY] (HEREINAFTER known as the “Agent”)as my Agent to make any and all medical decisions on my behalf, except to the extent I limit those decisions in this document. This power of attorney takes effect if my doctor certifies in writing that I can no longer make my own health care decisions. My agent can be reached at the following contact information:

Home Phone: [AGENT HOME PHONE] Work Phone: [AGENT WORK PHONE]

Cell Phone: [AGENT CELL PHONE] E-Mail: [AGENT EMAIL]

**AGENT LIMITATIONS**

My agent is authorized to make all medical decisions on my behalf **EXCEPT** for the following:

[LIST ALL AGENT LIMITATIONS HERE].

**APPOINTMENT OF ALTERNATE AGENT**

If my agent appointed above is unable or unwilling to serve as my agent, I appoint the following person(s) to serve as agents in the order set forth below with the authority to make health care decisions on my behalf as provided herein:

1. **First (1st)** Alternate Agent

Name: [1ST ALTERNATE AGENT NAME] Phone: [1ST ALTERNATE AGENT PHONE]

Address: [1ST ALTERNATE AGENT ADDRESS]

1. **Second (2nd)** Alternate Agent

Name: [2ND ALTERNATE AGENT NAME] Phone: [2ND ALTERNATE AGENT PHONE]

Address: [2ND ALTERNATE AGENT ADDRESS]

**ORIGINAL AND COPIES OF THIS DOCUMENT**

The original document is/will be filed in the following place:

[DESCRIBE WHERE THE ORIGINAL POWER OF ATTORNEY (THIS FORM) WILL BE KEPT].

I have/will provided copies of my medical power of attorney to the following:

[LIST ALL OF THE PERSON(S) THAT WILL BE RECEIVING A COPY OF THIS POWER OF ATTORNEY].

**DURATION**

Unless stated otherwise herein, this document shall remain in effect until I revoke it. I understand that I cannot revoke this document during the time I am considered incompetent to make my own decisions.

**(Optional - Initial and Check if applicable)**

[INITIALS] [ ]  This power of attorney shall expire on [MM/DD/YYYY].

**PRIOR MEDICAL POWER OF ATTORNEY**

By signing this document, I hereby revoke any and all prior medical powers of attorney that I may have executed.

**EXECUTION**

YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY. YOU MAY SIGN IT AND HAVE YOUR SIGNATURE ACKNOWLEDGED BEFORE A NOTARY PUBLIC

**OR**

YOU MAY SIGN IT IN THE PRESENCE OF TWO COMPETENT ADULT WITNESSES NOT RELATED BY BLOOD OR MARRIAGE.

**SIGNATURES**

I / We hereby execute this document on [MM/DD/YYYY], in the City of [SIGNING CITY], State of [SIGNING STATE].

**Principal’s Signature**:

Print Name: [PRINCIPAL PRINTED NAME]

**Agent’s Signature**:

Print Name: [AGENT PRINTED NAME]

**1st Alt. Agent’s Signature**:

Print Name: [1ST ALTERNATE AGENT PRINTED NAME]

**2nd Alt. Agent’s Signature**:

Print Name: [2ND ALTERNATE AGENT PRINTED NAME]

**NOTARY ACKNOWLEDGMENT**

STATE OF [NOTARY ONLY: STATE]

COUNTY [NOTARY ONLY: COUNTY] ss.

On [MM/DD/YYYY], before me appeared

[NOTARY ONLY: PRINCIPAL NAME], as Maker of this Medical Power of Attorney who proved to me through government issued photo identification to be the above-named person, in my presence executed foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notary Public**

Print Name: [NOTARY ONLY: NOTARY NAME]

My commission expires: [MM/DD/YYYY]

**- - - - - - - - - - - - - - - - - - - - - - OR - - - - - - - - - - - - - - - - - - - - - -**

**WITNESS STATEMENT AND ACKNOWLEDGMENT**

I am not the person appointed as agent or successor agent in this medical power of attorney. I am not related to the maker of this document by blood or marriage. I am not entitled to any portion of the maker's estate, nor do I have any claim against the maker’s estate. I am not the attending physician of the maker or an employee of the attending physician. I am not involved in providing direct patient care to the maker and am not an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility.

SIGNATURE OF FIRST WITNESS

**Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: [MM/DD/YYYY]

Print Name: [WITNESS PRINTED NAME]

Address: [WITNESS ADDRESS]

SIGNATURE OF SECOND WITNESS

**Signature**: [\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_](https://esign.com/) Date: [MM/DD/YYYY]

Print Name: [WITNESS PRINTED NAME]

Address: [WITNESS ADDRESS]