Durable Power of Attorney for Health Care

I, _____ of _____ Michigan,
(Name) (City)

hereby appoint _____
(Patient Advocate)

residing at

_____,
(Patient Advocate Address)

as my attorney in fact (herein called patient advocate) with the following power to be exercised in my name and for my benefit, including, but not limited to, making decisions regarding my care, custody or medical treatment. This power of attorney has effect only if I become unable to participate in treatment decisions.

If the first individual is unable, unwilling or unavailable to serve as my patient advocate, then I designate

_____, residing at
(Successor Patient Advocate)

_____, to serve as my patient advocate.
(Successor Patient Address)

With respect to my personal care, my advocate shall have the power to make each and every judgment necessary for the proper and adequate care and custody of my person, including, but not limited to:

(If any of the following do not apply, I may cross them out and place my initials next to the item.)

A. To have access to and control over my medical and other personal information.
B. To employ and discharge physicians, nurses, therapists and any other care providers, and to pay them reasonable compensation.
C. To give an informed consent or an informed refusal on my behalf with respect to any medical care; diagnostic, surgical or therapeutic procedure; or other treatment of any type or nature, including life sustaining treatments such as artificial nutrition and hydration.
D. To execute waivers, medical authorizations and such other approval as may be required to permit or authorize care that I may need or to discontinue care that I am receiving.
E. To make decisions that could or would allow my death (except if I am pregnant).
F. My advocate shall be guided in making such decisions by what I have told my advocate about personal preferences regarding such care. Some of those preferences may be recorded below:

(Recording any of your preferences is optional*.)*

My wishes concerning care are as follows:

_____
_____
_____
_____

It is my intent that my family, the medical facility, and any doctors, nurses and other medical personnel involved in my care not be liable for implementing the decisions of my patient advocate or honoring wishes expressed in this designation.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

This document is to be treated as a Durable Power of Attorney and shall survive my disability or incapacity.

This document is signed in the state of Michigan. It is my intent that the laws of the state of Michigan govern all questions concerning its validity, the construction of its provisions and its enforceability. I also intend that it be applied to the fullest extent possible wherever I may be.

I voluntarily sign this Durable Power of Attorney after careful consideration. I understand its meaning and accept its consequences.

_____

(Signature) (Date)

_____

(Contract Number)

Witnesses:
(A witness shall not sign this Durable Power of Attorney unless the person appears to be of sound mind and under no duress, fraud or undue influence.)

Names and Addresses of Witnesses:

_____

(Witness 1 Name) (Witness 1 Address)

_____

(Witness 1 Signature)

_____

(Witness 2 Name) (Witness 2 Address)

_____

(Witness 2 Signature)

(A witness must be a disinterested individual and may not be the person's spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of the witnessing, physician, patient advocate, an employee of a life or health insurance provider for the patient, an employee of a health facility that is treating the patient, or an employee of a home for the aged.)