ADVANCE DIRECTIVE

Durable Power of Attorney for Health Care

I am making this Advance Directive to Inform my family, doctor(s) and all others involved with my care about my expressed wishes concerning the medical care I am to receive. I direct my family, doctor(s) and all others involved with my care to act in accordance with these expressed wishes.

Appointment of Patient Advocate

I, _____, appoint the following person to be
Print your name

my patient advocate: _____.
Type or print Patient Advocate's Name

Appointment of Successor Patient Advocate(s)

I appoint the following person(s) as my Successor Patient Advocate if my Patient Advocate does not accept my appointment, is incapacitated, resigns or is removed. My Successor Patient Advocate is to have the same powers and rights as my Patient Advocate.

Name: _____
Type or print

Name: _____
Type or print

My Patient Advocate or Successor Patient Advocate may delegate his/her powers to the next Successor Patient Advocate if he or she is not able to act.

My Patient Advocate or Successor Patient Advocate may act only if I am unable to participate in making decisions regarding my medical treatment.

Here you name someone to act for you regarding your care, custody and treatment. This person is called a "Patient Advocate." You may name anyone who is at least 18 years old and of sound mind. You may also name more persons to act if your first choice cannot. If you change your mine, you may revoke your appointment of Patient Advocate at any time.

Instructions to Patient Advocate

1. General Instructions

My Patient Advocate shall have the authority to make all decisions and to take all actions regarding my care, custody and medical treatment, including but not limited to the following:

a. Have access to, obtain copies of and authorize release of my medical and other personal information.
b. Employ and discharge physicians, nurses, therapists, any other health care providers and other providers, and arrange to pay them reasonable compensation.
c. Consent to, refuse or withdraw for me any medical, diagnostic, surgical, or therapeutic procedure, or other treatment of any type or nature, including life-sustaining treatments. I understand that life-sustaining treatment includes but is not limited to breathing with the use of a machine and receiving food, water and other liquids through tubes. I also understand that these decisions could or would allow me to die. I have listed below any specific instructions I have related to life-sustaining treatments.

2. Specific Instructions

My Patient Advocate is to be guided in making medical decisions for me by what I have told him/her about my personal preferences regarding my care. Some of my preferences are recorded below and on the following pages. (You may list specific care and treatment you do or do not want. Otherwise, your General Instructions under number 1 above all will stand for your wishes.) I direct that reasonable measures be taken to keep me comfortable and relieve pain.

a. Specific Instructions Regarding Care I DO want. _____

_____

_____

_____

b. Specific Instructions Regarding Care I DO NOT want. _____

_____

_____

_____

c. Specific Instructions Regarding Life-Sustaining Treatment

I understand that I do not have to choose one of the three instructions regarding life-sustaining treatment listed below. If I choose one, I will sign below my choice. (Discuss these choices with your doctor and sign only one instruction.)

This section gives instructions for your care. Cross out and initial any instructions that you do not want. Under Instruction 1.b., your Patient Advocate has the right to make arrangements for your care but is not required personally to pay the cost of your care. Note: Current law does not permit your Patient Advocate to make decisions to withhold or withdraw treatment if you are pregnant if those decisions would result in your death, to engage in homicide or euthanasia, or to force medical treatment you do not want because of your religious beliefs.

Choice 1:
I do not want my life to be prolonged by providing or continuing life-sustaining treatment if any of the following medical conditions exits:

I am in an irreversible coma or persistent vegetative state.

I am terminally ill and life -sustaining procedures would serve only to artificially delay my death.

Under any circumstances where my medical condition is such that the burdens of the treatment outweigh the expected benefits. In weighing the burdens and benefits of treatment, I want my Patient Advocate to consider the relief of suffering and quality of my life as well as the extent of possibly prolonging my life.

I understand that decision could or would allow me to die.

If this statement reflects your desires, sign here: _____

Choice 2:
I want my life to be prolonged by life-sustaining treatment unless I am in a coma or vegetative state which my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I do not want life-sustaining treatment to be provided or continued. I understand that this decision could or would allow me to die.

If this statement reflects your desires, sign here: _____

Choice 3:
I want my life to be prolonged to the greatest extent possible consistent with sound medical practice without regard to my condition, the chances I have for recovery, or the cost of my care, and I direct life-sustaining treatment to be provided in order to prolong my life.

If this statement reflects your desires, sign here: _____

d. Specific Instructions Regarding Medical Examinations

My religious beliefs prohibit a medical examination to determine if I am able to participate in making medical decisions. I would like this determination made in the following manner:

_____

_____

_____

_____

e. Specific Instructions Regarding Anatomical Gifts

My Patient Advocate has the authority, upon or immediately before my death, to make an anatomical gift of all or a part of my body for therapy or transplantation needed by another individual; for medical or dental education, research, or the advancement of medical or dental science; for anatomical study; or for any other purpose permitted by law. This authority granted to my Patient Advocate shall remain exercisable following my death.

If this statement reflects your desires, sign here: _____

This document is to be treated as a Durable Power of Attorney for Health Care and shall survive my disability or incapacity. This document ceases to be valid upon my demise with the specific instructions regarding Anatomical Gifts.

If I am unable to participate in making decisions for my care and there is no Patient Advocate or Successor Patient Advocate able to act for me, I request that the instructions I have given in this document be followed and that this document be treated as conclusive evidence of my wishes.

It is also my intent that anyone participating in my medical treatment shall not be liable for following the directions of my Patient Advocate that are consistent with my instructions.

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

Photocopies or faxes of this document may be relied upon as though they were originals.

I am providing these instructions of my free will. I have not been required to give them in order to receive or have care withheld or withdrawn. I am at least 18 years old and of sound mind.

Signature: _____ Date: _____

Name: _____

Type or print

Address: _____

Keep the signed original with your personal papers at home. Give signed photocopies to your doctor, family, the facility where you are being treated and to your Patient Advocate(s).

You should review this document from time to time and when there is a change in your health or family status. When you review it, it is still expresses your intent, sign and date under the Reaffirmed section on the next page to show you still agree with its contents.

Witness Statement and Signature

I decided that the person who signed this Designation of Patient Advocate signed it in my presence and is known to me. I also declare that the person who signed appears to be of sound mind and under no duress, fraud, or undue influence and is not my husband, wife, partner, child, grandchild, brother or sister. I declare that I am not the presumptive heir of the person who signed the previous page, the known beneficiary of his/her will at the time of witnessing, his/her physician or a person named as the Patient Advocate. I also declare that I am not an employee of a life or health insurance provider for the person who signed, an employee of a health facility that is treating him/her, or an employee of a home for the aged where he/she resides, and that I am at least eighteen years old.

WITNESSES

Sign Name: _____

Name: _____
Type or Print

Address: _____

_____

Date: _____

Sign Name: _____

Name: _____
Type or Print

Address: _____

_____

Date: _____

Sign Name: _____

Name: _____
Type or Print

Address: _____

_____

Date: _____

REAFFIRMED

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Sign and date here in the presence of at least two witnesses who meet the requirements listed in the Witness Statement.

If the witness does not personally know the person who is signing this document, the witness should ask for identification, such as a driver's license. Only two witnesses are required. Using three will protect validity of the document if one witness is later found ineligible to be a witness. If your wishes change, destroy this document, make out a new one and give a copy to everyone who has a copy of the old version.

Acceptance of Patient Advocate Designation

The Patient Advocate and Successor Patient Advocate must sign this Acceptance before he/she may as act as Patient Advocate.

I, _____, agree to be

the Patient Advocate for _____
(called "Patient" in the rest of this document)

I accept the Patient's designation of me as Patient Advocate. I understand and agree to take reasonable steps to follow the desires and instructions of the Patient as indicated in the Designation of Patient Advocate, in other written instructions of the Patient and as we have discussed verbally.

I also understand and agree that:

a. This designation shall not become effective unless the Patient is unable to participate in medical treatment decisions, as applicable.

b. A Patient Advocate shall not exercise powers concerning the Patient's care, custody, medical treatment that the Patient – if the Patient were able to participate in the decision – could not have exercised on his or her own belief.

c. This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a Patient who is pregnant that would result in the pregnant Patient's death.

d. A Patient Advocate may make a decision to withhold or withdraw treatment which would allow a Patient to die only if the Patient has expressed in a clear and convincing manner that the Patient Advocate is authorized to make such a decision, and that the Patient acknowledges that such a decision could or would allow the Patient's death.

e. A Patient Advocate shall not receive compensation for the performance of his or her authority, rights and responsibilities, but a Patient Advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights and responsibilities.

f. A Patient Advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the Patient and shall act consistent with the Patient's best interest. The know desires of the Patient expressed or evidenced while the Patient is able to participate in medical or mental health treatment decisions are presumed to be in the Patient's best interests.

g. A Patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.

You should discuss this document with the person you want to have as your Patient Advocate and have him/her sign the Acceptance of Patient Advocate.
These restrictions are required by 1998 Public Act 386, MCLS § 700.5506 et seq.

h. A Patient Advocate may revoke his or her acceptance of the designation at any time and in any manner sufficient to communicate an intent to revoke.

i. A Patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, ACT No. 368 of the Public Acts of 1978, being Section 333.20201 of the Michigan Compiled Laws.

j. If the designation authorizes the Patient Advocate to make an anatomical gift, the authority remains exercisable after the Patient's death. A Patient Advocate may not exercise the authority to make an anatomical gift if the Patient Advocate has received actual notice that the Patient expressed an unwillingness to make the gift.

If I am unavailable to act after reasonable effort to contact me, I delegate my authority to the persons the Patient has designated as Successor Patient Advocate in the order designated. The Successor Patient Advocate is authorized to act until I become available to act.

PATIENT ADVOCATE

Sign Name: _____

Name: _____
Type or Print

Address: _____

Home Phone: _____ Work Phone: _____

SUCCESSOR PATIENT ADVOCATE

Sign Name: _____

Name: _____
Type or Print

Address: _____

Home Phone: _____ Work Phone: _____

SUCCESSOR PATIENT ADVOCATE

Sign Name: _____

Name: _____
Type or Print

Address: _____

Home Phone: _____ Work Phone: _____