DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, am of sound mind and I
(Print or type your full name)
voluntarily make this designation.

APPOINTMENT OF PATIENT ADVOCATE

I designate _____, my _____
(Insert name of patient advocate) (Spouse, child, friend …)

living at _____ as my patient advocate.
(Address of patient advocate)
If my first choice cannot serve, I designate _____,
(Name of successor patient advocate)
my_____, living at _____
(Spouse, child, friend ...) (Address of successor patient advocate)
to serve as patient advocate.

My patient advocate or successor patient advocate shall have power to make care, custody and medical treatment decisions for me in the event I become unable to participate in medical treatment decisions. I understand my patient advocate must sign an acceptance before he or she can act. I have discussed this appointment with the individual or individuals I have designated.

DIRECTIONS

The determination of when I am unable to participate in medical treatment decisions shall be made by my attending physician and another physician or licensed psychologist.

In making decisions, my patient advocate shall endeavor to follow my previously expressed wishes, whether I have stated them orally, in a living will, or in this designation.

My patient advocate has authority to consent to or refuse treatment on my behalf, to arrange medical and personal services for me, including admission to a hospital or nursing care facility, and to pay for such services with my funds. My patient advocate shall have access to any of my medical records to which I have a right.

POWER REGARDING LIFE-SUSTAINING TREATMENT

(OPTIONAL)

I expressly authorize my patient advocate to make decisions to withhold or withdraw treatment which would allow me to die, and I acknowledge such decisions could or would allow my death.

_____
(Sign your name if you wish to give your patient advocate this authority)

STATEMENT OF WISHES

My patient advocate has authority to make decisions in a wide variety of circumstances. In this document, I can express general wishes regarding conditions such as terminal illness, permanent unconsciousness, or other disability; specify particular types of treatment I do or not want in such circumstances; or I may state no wishes at all.

A. My wishes are as follows (you may attach additional sheets of paper):

_____
_____
_____
_____
_____

or

B. I choose not to express any wishes in this document. This choice shall not be interpreted as limiting the power of my patient advocate to make any particular decision in any particular circumstance.

I may change my mind at any time by communicating in any manner that this designation does not reflect my wishes.

It is my intent no one involved in my care shall be liable for honoring my wishes as expressed in this designation or for following the directions of my patient advocate.

Photocopies of this document can be relied upon as though they were originals.

SIGNATURE

I sign this document voluntarily, and I understand its purpose.

Dated: _____ Signed: _____
(Your signature)

_____
(Address)

STATEMENT REGARDING WITNESSES

I have chosen two adult witnesses who are not named in my will, who are not my spouse, child, grandchild, brother or sister, my physician, my patient advocate, an employee of my life or health insurance company, or an employee at the health care facility where I am now.

STATEMENT AND SIGNATURE OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

_____ _____
(Print name) (Signature of witness)

_____
(Address)

_____ _____
(Print name) (Signature of witness)

_____
(Address)

ACCEPTANCE BY PATIENT ADVOCATE

(A) This designation shall not become effective unless the patient is unable to participate in treatment decisions.

(B) A patient advocate shall not exercise powers concerning the patient's care, custody and medical treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.

(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 interests. The known desires of the patient expressed or evidenced while thepatientis able to participate in medical treatment decisions are presumed to be in the patient's best interests.

(G) A patient may revoke his or her designation at any time or in any manner sufficient to conununicate an intent to revoke.

(H) A patient advocate may revoke his or her acceptance to 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.

I, _____, understand the above
(Name of patient advocate)
conditions and I accept the designation as patient advocate for _____, who signed a durable power of
(Name of patient)
attorney for health care on the following date _____.

Dated: _____ Signed: _____
(Signature of patient advocate)