Durable Power of Attorney for Health Care
For Care, Custody and Medical Treatment Decisions

I, _____ am of sound mind, and I voluntarily make
(PRINT OR TYPE YOUR FULL NAME)
this designation.

I designate _____ ,
(INSERT NAME OF PATIENT ADVOCATE)

residing at _____
(ADDRESS OF PATIENT ADVOCATE)
as my patient advocate, with the following power to be exercised in my name for my benefit, to make decisions regarding care, custody or medical treatment if I become unable to participate in care, custody and medical treatment decisions. The determination of when I am unable to participate in care, custody and medical treatment decisions shall be made by my attending physician and another physician.

[(Optional) If the first individual is unable, unwilling or unavailable to serve as my patient advocate, then

I designate _____ ,
(NAME OF SUCCESSOR)

residing at _____
(ADDRESS OF SUCCESSOR)
to serve as my patient advocate.]

With respect to my care, custody and medical treatment, 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:

(a) to have access to and control over my medical and personal information;

(b) to employ and discharge physicians, nurses, therapists and any other care providers, and to pay them reasonable compensation with my funds;

(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;

(d to execute waivers, medical authorizations and such other approval as may be required to permit or authorize care which I may need, or to discontinue care that I am receiving.

My advocate shall be guided in making such decisions by what I have told my advocate about personal preferences regarding such care.

My wishes concerning care are the following:

_____

_____

_____

_____

OPTIONAL

I authorize my patient advocate to make a decision to withhold or withdraw treatment which could or would allow me to die. I acknowledge that such a decision could or would allow me to die.

_____
Sign this statement if you wish to give this authority to your advocate.

This Durable Power of Attorney shall not be affected by my disability or incapacity. This Durable Power of Attorney is governed by Michigan law. I may revoke this designation at any time and by communicating in any manner that this designation does not reflect my wishes.

(Continued)

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.

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

(YOUR SIGNATURE)

(YOUR STREET ADDRESS)

(DATE)

(CITY, MICHIGAN ZIP CODE)

Notice Regarding Witnesses

You must have two adult witnesses who should be disinterested individuals and must not be your spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of the witnessing, physician, patient advocate, an employee of your life or health insurance provider, an employee of a health facility that is treating you, or an employee of a home for the aged.

Statement 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, and under no duress, fraud or undue influence.

(WITNESS 1 SIGNATURE)

(WITNESS 2 SIGNATURE)

(PRINT OR TYPE FULL NAME)

(PRINT OR TYPE FULL NAME)

(ADDRESS)

(ADDRESS)

Acceptance by Patient Advocate

(A) This designation shall not become effective unless the patient is unable to participate in medical 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 on 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 the 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 the patient is 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 and in any manner sufficient to communicate 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 conditions and I accept the designation as patient advocate for:

Dated: _____ Signed: _____