~ Ohio ~

Durable Power of Attorney for Health Care Christian Version

NOTICE TO ADULT EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, EVEN IF THE ATTORNEY IN FACT HAS GENERAL AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR YOU UNDER THIS DOCUMENT, THE ATTORNEY IN FACT NEVER WILL BE AUTHORIZED TO DO ANY OF THE FOLLOWING:

1. Refuse or withdraw informed consent to life–sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standard, that either of the following applies:
    - (A) You are suffering from an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which
        - (i) there can be no recovery and
        - (ii) your death is likely to occur within a relatively short time if life–sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

(B) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

2. Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if he or she is not prohibited from doing so under #4 below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under #4 below). [YOU SHOULD UNDERSTAND THAT COMFORT CARE IS DEFINED IN OHIO LAW TO MEAN ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) WHEN ADMINISTERED TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH, AND ANY OTHER MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE THAT WOULD BE TAKEN TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH. CONSEQUENTLY, IF YOUR ATTENDING PHYSICIAN WERE TO DETERMINE THAT A PREVIOUSLY DESCRIBED MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN, THEN SUBJECT TO #4 BELOW, YOUR ATTORNEY IN FACT WOULD BE AUTHORIZED TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE];

3. Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

4. REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) TO YOU, UNLESS:
   (A) YOU ARE IN A TERMINAL CONDITION OR
   (B) YOUR ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED YOU DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT DEATH IS IMMINENT AND THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN.
   (C) IF, BUT ONLY IF, YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE, YOU AUTHORIZE THE ATTORNEY IN FACT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU BY DOING BOTH THE FOLLOWING IN THIS DOCUMENT:
      (i) INCLUDING A STATEMENT IN CAPITAL LETTER OR OTHER CONSPICUOUS TYPE, INCLUDING, BUT NOT LIMITED TO, A DIFFERENT FONT, BIGGER TYPE, OR BOLDFACE TYPE, THAT THE ATTORNEY IN FACT MAY REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU IF YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE AND IF THE DETERMINATION THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN IS MADE, OR CHECKING OR OTHERWISE MARKING A BOX OR LINE (IF ANY) THAT IS ADJACENT TO A SIMILAR STATEMENT ON THIS DOCUMENT;
      (ii) PLACING YOUR INITIALS OR SIGNATURE UNDERNEATH OR ADJACENT TO THE STATEMENT, CHECK OR OTHER MARK PREVIOUSLY DESCRIBED.

(D) YOUR ATTENDING PHYSICIAN DETERMINES, IN GOOD FAITH, THAT YOU AUTHORIZED THE ATTORNEY IN FACT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU IF YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE BY COMPLYING WITH THE ABOVE REQUIREMENTS OF (4)(i) AND (ii) ABOVE.

5. Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising his authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to him in another manner. Specific details are listed and explained in the accompanying Addendum. The attorney in fact will receive direction for such decisions in that Addendum.

When acting pursuant to this document, the attorney in fact GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Generally, you can designate any competent adult as the attorney in fact under this document. However, you CANNOT designate your attending physician, or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you CANNOT designate an employee or agent of your attending physician or an employee or agent of a health care facility at which you are being treated as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your Durable Power of Attorney for Health Care generally will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you make your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicate it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption, may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]

STATE OF OHIO
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

Written in accordance with Ohio Revised Code §1337.17

[The completed form may be acknowledged by a notary public who is not an appointed primary or secondary attorney in fact or by two eligible witnesses.]

APPOINTMENT OF ATTORNEY IN FACT

I appoint _____ whose address is _____,
Name of attorney in fact Street

_____, _____, _____, and whose telephone number is
City State Zip Code

(_____) _____ as my attorney in fact for health care.
Phone

APPOINTMENT OF SUCCESSOR ATTORNEY IN FACT

The State of Ohio does not require the selection of a successor attorney in fact, but we suggest you select one anyway. The successor attorney in fact will assume the role of attorney in fact when the primary attorney in fact in unable or unwilling to assume the duties as outlined in this durable power of attorney document.

I appoint _____ whose address is _____,
Name of successor attorney in fact Street

_____, _____, _____, and whose telephone number is
City State Zip Code

(_____) _____ as my successor attorney in fact for health care.
Phone

The principal and two witnesses or a notary public must sign the document at the same time.

STATEMENT OF PRINCIPAL

I HAVE READ THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE. I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY ATTORNEY IN FACT, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT. I ALSO UNDERSTAND THAT I CAN REQUIRE IN THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

_____ _____
Signature of principal Date

DECLARATION OF WITNESSES OR NOTARY PUBLIC

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this Durable Power of Attorney for Health Care in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney in fact by this document.

Witnessed By:

Signature of witness	Date	Printed name of witness
Signature of witness	Date	Printed name of witness

OR

State of Ohio,)
)
) ss.
County of _____)

I, _____, a Notary Public of said County, do certify that,
Name of Notary Public

_____, whose name is affixed to the above durable power of attorney for health care as
Name of Principal
principal, has signed this document in my presence. I declare that he or she appears in sound mind and not under duress or undue influence, that he or she acknowledges the execution of the same to be his or her voluntary act and deed, and that I am not the attorney in fact or successor attorney in fact designated by this durable power of attorney for health care.

Witness by hand and notarial seal on ____/_____/_____.

_____
Signature of Notary Public
Seal

My Commission expires: ____/____/____

ADDENDUM TO THE STATE OF OHIO DURABLE POWER OF ATTORNEY FOR HEALTH CARE

GENERAL STATEMENT OF AUTHORITY GRANTED

As the declarant of this document, I desire to have my health care decisions made in accordance with this Addendum to the Durable Power of Attorney for Health Care – Christian Version. The purposes of this Addendum are to provide a witness to my Christian belief that life is a gift from God, and to provide direction for my attorney in fact to make decisions that are consistent with my Christian faith.

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my attorney in fact, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my attorney in fact and believe that he or she understands any philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my attorney in fact under this document.

If I am unable, due to my incapacity, to participate in making a health care decision, my attorney in fact is instructed to make the health care decision for me, but my attorney in fact should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my attorney in fact shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my attorney in fact shall base his or her health care decision on what he or she believes to be in my best interest.

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief that life is a gift from God and in the inherent value of human life. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my attorney in fact to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My attorney in fact has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my attorney in fact to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My attorney in fact may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my attorney in fact may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my attorney in fact may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, this condition must be diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition. Upon such diagnosis, my attorney in fact may consent to the withholding or withdrawal of certain life–sustaining health care, remaining faithful to the directives found in the rest of this document. I still desire health care for easily treatable acute and chronic conditions and health care that is intended to relieve pain or make me comfortable.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I check "Yes" to the "Withhold or withdraw a feeding tube" option in the next section, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my attorney in fact may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my attorney in fact may not have a feeding tube withheld or withdrawn from me.

My attorney in fact may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube: **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my attorney in fact may not have a feeding tube withheld or withdrawn from me.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My attorney in fact is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

PROVISION FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my attorney in fact may make health care decisions for me if he/she knows I am pregnant. If I have checked "No" to the following, my attorney in fact may not make health care decisions for me if he/she knows I am pregnant.

Health care decisions if I am pregnant: **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my attorney in fact may not make health care decisions for me if he or she knows I am pregnant.

In no event is my attorney in fact authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My attorney in fact may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, or a treatment facility. My attorney in fact may not consent to experimental mental health research or psycho surgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my attorney in fact has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

HIPAA RELEASE STATEMENT

I intend for my attorney in fact to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my attorney in fact the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act of 1996.

ADMISSION TO NURSING HOMES

My attorney in fact may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my attorney in fact may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my attorney in fact may not so admit me:

A nursing home: **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my attorney in fact may only admit me for short–term stays for recuperative care or respite care.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

In exercising authority under this document, my attorney in fact shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions, or limitations that I wish to state (add more items as appropriate):

1. I request that the attached Addendum (pages 6-12) be included as a valid part of this Durable Power of Attorney for Health Care document.

2. I request, but not as a requirement, that my attorney in fact consult with my clergy regarding health care decisions.

3. _____

_____

_____

_____

_____

_____

_____

[Attach additional pages, if needed]

ANATOMICAL GIFTS
Optional

Upon my death:

_____ I wish to donate only the following organs or parts:

_____

_____

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study if needed.

_____ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failure to check any of the lines immediately above creates no presumption about my desire to make or refusal to make an anatomical gift.

Signature: _____ Date: _____

The principal and two witnesses or a notary public must sign the document at the same time.

STATEMENT OF PRINCIPAL

I HAVE READ THIS ADDENDUM TO THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE. I UNDERSTAND THAT IT ALLOWS ANOTHER PERSON TO MAKE LIFE AND DEATH DECISIONS FOR ME IF I AM INCAPABLE OF MAKING SUCH DECISIONS. I ALSO UNDERSTAND THAT I CAN REVOKE THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE AT ANY TIME BY NOTIFYING MY ATTORNEY IN FACT, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT. I ALSO UNDERSTAND THAT I CAN REQUIRE IN THIS DURABLE POWER OF ATTORNEY FOR HEALTH CARE THAT THE FACT OF MY INCAPACITY IN THE FUTURE BE CONFIRMED BY A SECOND PHYSICIAN.

_____ _____
Signature of principal Date

DECLARATION OF WITNESSES OR NOTARY PUBLIC

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this Durable Power of Attorney for Health Care in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney in fact by this document.

Witnessed By:

_____ _____ _____
Signature of witness Date Printed name of witness

_____ _____ _____
Signature of witness Date Printed name of witness

OR

State of Ohio,)
)
) ss.
County of _____)

I, _____, a Notary Public of said County, do certify that,
Name of Notary Public

_____, whose name is affixed to the above durable power of attorney for health care as
Name of Principal
principal, has signed this document in my presence. I declare that he or she appears in sound mind and not under duress or undue influence, that he or she acknowledges the execution of the same to be his or her voluntary act and deed, and that I am not the attorney in fact or successor attorney in fact designated by this durable power of attorney for health care.

Witness by hand and notarial seal on ____/____/____.

_____
Signature of Notary Public
Seal

My Commission expires: ____/____/____

STATEMENT OF ATTORNEY IN FACT
AND SUCCESSOR ATTORNEY IN FACT

I understand that _____ has designated me to be his or her attorney in fact
Name of principal
or successor attorney in fact if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself. This designation shall not become effective unless the principal is unable to participate in medical treatment decisions.

_____ has discussed his or her desires regarding health care decisions with me.
Name of principal

Attorney in fact's signature: _____

Address: _____

Successor Attorney in fact's signature: _____

Address: _____

CLERGY

Optional

The principal has requested that the attorney in fact consult me, as the principal's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the attorney in fact to help meet the directives as described in this Durable Power of Attorney for Health Care document and attached Addendum.

Clergy's signature: _____ Phone: (_____) _____

Church address: _____

I have given copies of this Durable Power of Attorney for Health Care – Christian Version to:

_____

_____

_____

_____

_____

_____