~ Ontario ~

Power of Attorney For Personal Care Christian Version

NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long–term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person or persons whom you want to make health care decisions for you if you are unable to participate in medical treatment decisions and make those decisions personally. That person serves as your proxy and is known as your attorney for personal care, or simply attorney. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your attorney. If your attorney is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your attorney broad powers to make health care decisions for you. It revokes any prior power of attorney for personal care that you may have made. If you wish to change your power of attorney for personal care, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your attorney for personal care, your health care provider(s), and any other person(s) to whom you have given a copy. If your attorney is your spouse and your marriage is annulled or you are divorced after signing this document, the document is invalid.

You may also use this document to make or refuse to make an anatomical gift upon your death. If you use this document to make or refuse to make an anatomical gift, this document revokes any prior document of gift that you may have made. You may revoke or change any anatomical gift that you make by this document by crossing out the anatomical gifts provision in this document.

Do not sign this document unless you clearly understand it.

ONTARIO
POWER OF ATTORNEY
FOR PERSONAL CARE

Written in accordance with the *Substitute Decisions Act, 1992* – Province of Ontario

Document made this _____ day of _____, _____.
Month Year

CREATION OF POWER OF ATTORNEY FOR PERSONAL CARE

I, _____, _____,
Print full legal name Address

_____/_____/_____, being of sound mind, intend by this document to create a power of attorney for personal care.
Date of birth

My executing this power of attorney for personal care is voluntary. Despite the creation of this power of attorney for personal care, I expect to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For the purposes of this document, "health care decision" means an informed decision to accept, maintain, discontinue, or refuse any care, treatment, service, or procedure to maintain, diagnose, or treat my physical or mental condition.

In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

DESIGNATION OF ATTORNEY FOR PERSONAL CARE

If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate

_____, _____,
Attorney for Personal Care Address

_____, to be my attorney for the purpose of making health care decisions on my behalf.
Phone

If he or she is ever unable or unwilling to serve as my attorney, I hereby designate:

First Alternate _____ _____
Name Phone

_____
Address

I wish to designate additional Alternate Attorney(s) for Personal Care, listed here in preferential order:

Second Alternate _____ _____
Name Phone

_____
Address

Third Alternate

Name _____ Phone _____

Address _____

Fourth Alternate

Name _____ Phone _____

Address _____

to be my alternate attorney(s) for the purpose of making health care decisions on my behalf. Neither my attorney nor my alternate attorney(s) whom I have designated, is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient or a spouse of any of those persons, unless he or she is also my relative. Neither my attorney nor any alternate attorneys whom I have designated are currently serving in positions in which they receive compensation to provide care or other services to me. For purposes of this document, "incapacity for personal care" exists if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

If I am incapacitated and unable to make my own health care decisions, I have the choice of requiring my attorneys for personal care to act individually or collectively as a group. If I designate they act individually, then my primary attorney will make the decisions. If my primary attorney is unable or unwilling to serve in that capacity, then my first alternate attorney will make the decisions. If both my primary attorney and my first alternate attorney are unable or unwilling to serve, then my second alternate attorney will make the decisions. If I designate they act as a group, they must agree before making health care decisions for me.

I direct my attorneys to act:

- ☐ **Individually**
- ☐ **As a Group**

If I have designated that my attorneys act as a group, I must determine the method for resolving disagreements. If my attorneys disagree, I can determine they settle disagreements by authorizing the primary or highest alternate to make the decision, or I can determine that the majority opinion determines the decision.

I direct that disagreements be settled by:

- ☐ **Following directions of primary attorney**
- ☐ **Following directions of the majority**

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have an incapacity I instruct my health care provider to obtain health care decisions from my attorney for all of my health care and treatment. I have discussed my desires thoroughly with my attorney 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 for personal care under this document.

If I am unable, due to my incapacity, to participate in making a health care decision, my attorney is instructed to make the health care decision for me, but my attorney 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 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 shall base his or her health care decision on what he or she believes to be in my best interest.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

In exercising authority under this document, my attorney 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 6-9) be included as a valid part of this Power of Attorney for Personal Care document.

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

3. _____

_____

_____

_____

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

Subject to any limitations in this document, my attorney 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.

The person creating this document and the witnesses must sign the document at the same time.

SIGNATURE OF THE GRANTOR

(Person creating this Power of Attorney for Personal Care)

Signature: _____ Date: _____

(The signing of this document revokes all previous power of attorney for personal care documents.)

STATEMENT OF WITNESSES

I know the grantor creating this document personally and I believe him or her to be of sound mind and at least 16 years of age. I believe that his or her execution of this power of attorney for personal care is voluntary. I am at least 18 years of age, am not related to the grantor by blood, marriage, or adoption and am not directly financially responsible for the grantor's health, residential, social, or support care. I am not a health care provider who is serving the grantor at this time, an employee of the health care provider, other than a chaplain or a social worker, or an employee of an inpatient health care facility in which the grantor is a patient. I am not the grantor's attorney for personal care. To the best of my knowledge, I am not entitled to and do not have a claim on the grantor's estate.

Witness #1

Print name: _____ Date: _____

Address: _____

Signature: _____

Witness #2

Print name: _____ Date: _____

Address: _____

Signature: _____

STATEMENT OF ATTORNEY(S) FOR PERSONAL CARE

I understand that I have been designated as an attorney for personal care. By signing this document, I agree to serve in that role as I am able.

Attorney's Name: _____ **Date:** _____

Attorney's Signature: _____

First Alternate Attorney's Name: _____ **Date:** _____

First Alternate Attorney's Signature: _____

Second Alternate Attorney's Name: _____ **Date:** _____

Second Alternate Attorney's Signature: _____

Third Alternate Attorney's Name: _____ **Date:** _____

Third Alternate Attorney's Signature: _____

Fourth Alternate Attorney's Name: _____ **Date:** _____

Fourth Alternate Attorney's Signature: _____

ADDENDUM TO THE ONTARIO POWER OF ATTORNEY FOR PERSONAL CARE

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 in the inherent value of human life and that life is a gift from God. 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 exists 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 for personal care 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 has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my attorney 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 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 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 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, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my attorney 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.

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. 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;
   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; or
   c. Continuing artificially administered nutrition and hydration would hasten my death.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My attorney 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.

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: _____

CLERGY
Optional

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

Clergy's signature: _____ Phone: _____

Church address: _____

The person creating this Addendum and the witnesses must sign the document at the same time.

SIGNATURE OF THE GRANTOR

Signature: _____ Date: _____

(This signing indicates agreement with the additional directives of this Addendum.)

STATEMENT OF WITNESSES

I know the grantor creating this document personally and I believe him or her to be of sound mind and at least 16 years of age. I believe that his or her execution of this power of attorney for personal care is voluntary. I am at least 18 years of age, am not related to the grantor by blood, marriage, or adoption and am not directly financially responsible for the grantor's health, residential, social, or support care. I am not a health care provider who is serving the grantor at this time, an employee of the health care provider, other than a chaplain or a social worker, or an employee of an inpatient health care facility in which the grantor is a patient. I am not the grantor's attorney for personal care. To the best of my knowledge, I am not entitled to and do not have a claim on this grantor's estate.

Witness #1

Print name: _____ Date: _____

Address: _____

Signature: _____

Witness #2

Print name: _____ Date: _____

Address: _____

Signature: _____

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

_____

_____

_____

_____

_____

_____