~ Rhode Island ~

Durable Power of Attorney For Health 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 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 is known as your health care agent. 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 health care agent (attorney in fact). If your health care agent 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 agent broad powers to make health care decisions for you. It revokes any prior power of attorney for health care that you may have made. If you wish to change your Power of Attorney for Health 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 agent, your health care provider(s), and any other person(s) to whom you have given a copy. If your agent is your spouse and your marriage is annulled or you are divorced after signing this document, the document is invalid.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document with your personal papers where it can be easily accessed by your health care agent, close family, or friends, if needed.

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document which is authorized by the general laws of this state. Before executing this document, you should know these facts:

You must be at least eighteen (18) years of age and a resident of the state of Rhode Island for this document to be legally valid and binding.

This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection at the time, and health care necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitation that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of the agent to make health care decisions for you if your agent:

1. Authorizes anything illegal,

2. Acts contrary to your known desires, or

3. Where your desires are not known, does anything that is clearly contrary to your best interests.

Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death except to inform your next of kin of your desire to be an organ and tissue donor.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other health care provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

This document revokes any prior durable power of attorney for health care.

You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure.

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

Your agent may need this document immediately in case of an emergency that requires a decision concerning your health care. Either keep this document where it is immediately available to your agent and alternate agents or give each of them an executed copy of this document. You may also want to give your doctor an executed copy of this document.

STATE OF RHODE ISLAND
DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

Written in accordance with Rhode Island General Laws §23-4.10-2

DESIGNATION OF HEALTH CARE AGENT

As the principal of this durable power of attorney for health care document, you may select only one individual as your agent to make health care decisions for you. None of the following may be designated as your agent: (1) Your treating care provider, (2) A nonrelative employee of your treating health care provider, (3) An operator of a community care facility, or (4) A nonrelative employee or an operator of a community care facility.

I, _____ (Name of principal), _____ (Address),

do hereby designate and appoint: _____ (Name of agent), _____ (Street),

_____ (City), _____ (State), _____ (Zip Code), (_____) _____ (Phone number) as my attorney in fact (agent) to make health care decisions for me as authorized in this document. For the purposes of this document, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

By this document I intend to create a durable power of attorney for health care.

GENERAL STATEMENT OF AUTHORITY GRANTED

Subject to any limitations in this document, I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining, refusing, or withdrawing life-prolonging care, treatment, services, and procedures and informed my family or next of kin of my desire, if any, to be an organ or tissue donor.

[If you want to limit the authority of your agent to make health care decisions for you, you can state the limitation on the lines ("Statement of Desires, Special Provisions, and Limitations") provided. You can indicate your desires by including a statement of your desires in the same paragraph.]

STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS

Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by

discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

1. Statement of desires concerning life-prolonging care, treatment, services, and procedures:

_____

_____

_____

_____

_____

[Attach additional pages, if needed – see instructions below.]

2. Additional statement of desires, special provisions, and limitations regarding health care decisions:

a. I request that the attached Addendum (pages 9-15) be included as a valid part of this Durable Power of Attorney for Health Care document.

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

_____

_____

_____

_____

_____

[You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.]
If you wish to make a gift of any bodily organ you may do so pursuant to the Uniform Anatomical Gift Act.

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

Subject to any limitations in this document, my agent has the power and authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.

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

3. Consent to the disclosure of this information.

[If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in the section titled "STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS" above.]

SIGNING DOCUMENTS, WAIVERS, AND RELEASES

Where necessary to implement the health care decisions that my agent is authorized by this document to make, my agent has the power and authority to execute on my behalf all of the following:

1. Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."

2. Any necessary waiver or release from liability required by a hospital or physician.

DURATION

(Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.)

This durable power of attorney for health care expires on: _____

(Fill in this space ONLY if you want authority of your agent to end on a specific date.)

DESIGNATION OF ALTERNATE AGENTS

(You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designate on page 3, in the event that agent is unable or ineligible to act as your agent. If the agent you designate is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)

If the person designated as my agent on page 3 is not available or becomes ineligible to act as my agent to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

First Alternate Agent

Name: _____ Phone: (____) _____

Address: _____

_____

Second Alternate Agent

Name: _____ Phone: (____) _____

Address: _____

_____

PRIOR DESIGNATIONS REVOKED

I revoke any prior durable power of attorney for health care.

HIPAA RELEASE STATEMENT

I intend for my health care agent 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 agent 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 (HIPAA) of 1996.

SIGNATURE OF PRINCIPAL

(YOU MUST DATE AND SIGN THIS DURABLE POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney for Health Care on _____ at
Date

_____, _____.
City State

Signature: _____

THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY TWO (2) QUALIFIED WITNESSES OR WITNESSED BY A NOTARY PUBLIC WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.

STATEMENT OF WITNESSES

This document must be witnessed by two (2) qualified adult witnesses or one (1) notary public. None of the following may be used as a witness:

1. A person you designate as your agent or alternate agent,
2. A health care provider,
3. An employee of a health care provider,
4. The operator of a community care facility,
5. An employee of an operator of a community care facility.

I declare under penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee or an operator of a community care facility.

OPTION 1 – Two (2) Qualified Witnesses:

Witness #1

Signature: _____ Date: _____

Print name: _____

Address: _____

Witness #2

Signature: _____ Date: _____

Print name: _____

Address: _____

At least one of the above witnesses or the notary public must also sign the following declaration.

I further declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____ Print name: _____

Signature: _____ Print name: _____

OR

OPTION 2 – Notary Public

I, _____, sign my name to this durable power of
Print Name

attorney for health care on _____, at _____, _____,
Date City State

Principal's Signature: _____

NOTARY PUBLIC

_____ COUNTY

In the City/Town of _____ and County and State aforesaid, on the

_____ day of _____, 20_____, personally came

_____,

that the principal signed or acknowledged this durable power of attorney for health care in my presence, and that the principal appears to be of sound mind and under no duress, fraud, or undue influence. I further attest that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____
NOTARY PUBLIC

My commission expires on: _____

_____ Personally known by me

_____ Produced identification

ADDENDUM TO THE STATE OF RHODE ISLAND DURABLE POWER OF ATTORNEY FOR HEALTH 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 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 agent 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 agent has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my agent 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 agent 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 agent 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 health care agent 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 agent 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. 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 agent 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 agent may not have a feeding tube withheld or withdrawn from me.

My agent 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 agent may not have a feeding tube withheld or withdrawn from me.

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My agent 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 agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my agent may not make health care decisions for me if my agent knows I am pregnant.

Health care decision if I am pregnant **Yes ❑** **No ❑**

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

In no event is my agent 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 agent 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 agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES

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

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

A nursing home **Yes ❑** **No ❑**

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

SIGNATURE OF PRINCIPAL

(Person creating the Durable Power of Attorney for Health Care)

I HAVE READ THIS ADDENDUM TO THE RHODE ISLAND DURABLE POWER OF ATTORNEY FOR HEALTH CARE – CHRISTIAN VERSION. 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 AND ADDENDUM AT ANY TIME BY NOTIFYING MY AGENT, MY PHYSICIAN, OR THE FACILITY IN WHICH I AM A PATIENT OR RESIDENT.

I sign my name to this Addendum to the Rhode Island Durable Power of Attorney for Health Care – Christian Version on

_____ day of _____, _____ at _____, _____
Date Month Year City State

Signature: _____ Print name: _____
Principal

STATEMENT OF WITNESSES

[This document must be witnessed by two (2) qualified adult witnesses or one (1) notary public. None of the following may be used as a witness: (1) A person you designate as your agent or alternate agent, (2) A health care provider, (3) An employee of a health care provider, (4) The operator of a community care facility, (5) An employee or an operator of a community care facility.]

I declare under penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, nor an employee or an operator of a community care facility.

OPTION 1 – Two (2) Qualified Witnesses:

Witness #1

Signature: _____ Date: _____

Print name: _____

Address: _____

Witness #2

Signature: _____ Date: _____

Print name: _____

Address: _____

At least one of the above witnesses or the notary must also sign the following declaration.

I further declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____ Print name: _____

Signature: _____ Print name: _____

OR

OPTION 2 – Notary Public

I, _____, sign my name to this durable power of
Print Name

attorney for health care on _____, at _____, _____,
Date City State

Principal's Signature: _____

NOTARY PUBLIC

_____ COUNTY

In the City/Town of _____ and County and State aforesaid, on the

_____ Day of _____, 20_____, personally came

_____,

that the principal/declarant signed or acknowledged this durable power of attorney for health care in my presence, and that the principal appears to be of sound mind and under no duress, fraud, or undue influence. I further attest that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____
NOTARY PUBLIC

My commission expires on: _____

_____ Personally known by me

_____ Produced identification

STATEMENT OF AGENT

I understand that _____ has designated me to be his or her agent if he or she is
Name of principal
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

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

Address: _____

STATEMENT OF ALTERNATE AGENTS

Recommended, but not required

I understand that _____ has designated me to be his or her alternate health
Name of principal
care agent 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 and the primary health care agent is unable or unwilling to follow the directives as described in this Durable Power of Attorney and attached Addendum.

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

First alternate agent's signature: _____ Phone: (_____) _____

Address: _____

Second alternate agent's signature: _____ Phone: (_____) _____

Address: _____

CLERGY

Optional

The principal has requested that the agent 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 agent to help meet the directives as described in this Durable Power of Attorney for Health Care document and attached Addendum.

Clergy's signature: _____

Church name: _____ Phone: (_____) _____

Church Address: _____

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

_____

_____

_____

_____

_____

_____