B. EMPLOY AND DISCHARGE MY HEATH CARE PROVIDERS;

C. AUTHORIZE MY ADMISSION TO OR DISCHARGE FROM (INCLUDING TRANSFER TO ANOTHER FACILITY) ANY HOSPITAL, HOSPICE, NURSING HOME, ADULT HOME, OR OTHER MEDICAL CARE FACILITY; AND

D. CONSENT TO THE PROVISION, WITHHOLDING, OR WITHDRAWAL OF HEALTH CARE, INCLUDING, IN APPROPRIATE CIRCUMSTANCES, LIFE-SUSTAINING PROCEDURES.

(3) THE AUTHORITY OF MY AGENT IS SUBJECT TO THE FOLLOWING PROVISIONS AND LIMITATIONS:

_____

_____

_____

(4) MY AGENT'S AUTHORITY BECOMES OPERATIVE (INITIAL THE OPTION THAT APPLIES):

_____ WHEN MY ATTENDING PHYSICIAN AND A SECOND PHYSICIAN DETERMINE THAT I AM INCAPABLE OF MAKING AN INFORMED DECISION REGARDING MY HEALTH CARE; OR

_____ WHEN THIS DOCUMENT IS SIGNED.

(5) MY AGENT IS TO MAKE HEALTH CARE DECISIONS FOR ME BASED ON THE HEALTH CARE INSTRUCTIONS I GIVE IN THIS DOCUMENT AND ON MY WISHES AS OTHERWISE KNOWN TO MY AGENT. IF MY WISHES ARE UNKNOWN OR UNCLEAR, MY AGENT IS TO MAKE HEALTH CARE DECISIONS FOR ME IN ACCORDANCE WITH MY BEST INTEREST, TO BE DETERMINED BY MY AGENT AFTER CONSIDERING THE BENEFITS, BURDENS, AND RISKS THAT MIGHT RESULT FROM A GIVEN TREATMENT OR COURSE OF TREATMENT, OR FROM THE WITHHOLDING OR WITHDRAWAL OF A TREATMENT OR COURSE OF TREATMENT.

(6) MY AGENT SHALL NOT BE LIABLE FOR THE COSTS OF CARE BASED SOLELY ON THIS AUTHORIZATION.

BY SIGNING BELOW, I INDICATE THAT I AM EMOTIONALLY AND MENTALLY COMPETENT TO MAKE THIS APPOINTMENT OF A HEALTH CARE AGENT AND THAT I UNDERSTAND ITS PURPOSE AND EFFECT.

_____ _____

(DATE) (SIGNATURE OF DECLARANT)

THE DECLARANT SIGNED OR ACKNOWLEDGED SIGNING THIS APPOINTMENT OF A HEALTH CARE AGENT IN MY PRESENCE AND BASED UPON MY PERSONAL OBSERVATION APPEARS TO BE A COMPETENT INDIVIDUAL.

_____ _____

(WITNESS) (WITNESS)