DIRECTIVE TO PHYSICIANS
and
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I. DIRECTIVE TO PHYSICIANS

Directive made this ______ day of ____________________, _____. I, ____________________, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth in this directive.

A. LIFE-SUSTAINING PROCEDURES. If at any time I should have an incurable or irreversible condition caused by injury, disease, or illness certified to be a terminal condition or a permanently unconscious condition by two physicians, and if the application of life-sustaining procedures would serve only to artificially postpone the moment of my death and if my attending physician determines that my death is imminent or will result within a relatively short time without application of life-sustaining procedures, or that I will remain in a permanently unconscious condition, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

B. NUTRITION AND HYDRATION. If I have a condition stated above, it is my preference NOT TO RECEIVE artificially administered nutrition and hydration (food and fluids).

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

This directive is in effect until it is revoked. I understand the full import of this directive and I am emotionally and mentally competent to make this directive. I understand that I may revoke this directive at any time.

INFORMATION CONCERNING THE
DURABLE POWER OF ATTORNEY FOR HEALTH CARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your Agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition, your Agent has the power to make a broad range of health care decisions for you. Your Agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your Agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery, or abortion. A physician must comply with your Agent's instructions or allow you to be transferred to another physician.

Your Agent's authority begins when your doctor certifies that you lack the capacity to make health care decisions.

Your Agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your Agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

_____Int.

The person you appoint as Agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your Agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your Health Care Agent. You should discuss this document with your Agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your Agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your Agent by informing your Agent or your health or residential care provider orally or in writing, or by your execution of a subsequent Durable Power of Attorney for Health Care. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an Alternate Agent in the event that your Agent is unwilling, unable, or ineligible to act as your Agent. Any Alternate Agent you designate has the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO OR MORE QUALIFIED WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES.

(1) the person you have designated as your Agent;
(2) your health or residential care provider or an employee of your health or residential care provider;
(3) your spouse;
(4) your lawful heirs or beneficiaries named in your will or a deed;
(5) or creditors or persons who have a claim against you.

II. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

A. DESIGNATION OF HEALTH CARE AGENT. I, ____________, appoint:

Agent Name: ____________________________________
Address: ____________________________________
____________________________, ___ ___________
Phone: Home: _______________ Work: _______________
Relation, if any: None

as my Agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. This Durable Power of Attorney for Health Care takes effect if I become unable to make my own health care decisions and this fact is certified in writing by my physician.

It is my desire that my Agent act consistently with my wishes as stated elsewhere in this document or otherwise made known. This document gives my Agent the authority to make any health care decision I could make consistent with the law of this state and including decisions to withhold or withdraw life-sustaining procedures, including artificially administered nutrition and hydration.

NOTICE: A person may not exercise the authority of an Agent while the person serves as:
(1) the Principal's health care provider;
(2) an employee of the Principal's health care provider unless the person is a relative of the Principal;

(3) the Principal's residential care provider; or
(4) an employee of the Principal's residential care provider unless the person is a relative of the Principal.

B. LIMITATIONS ON THE DECISION-MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS: None.

C. DESIGNATION OF ALTERNATE AGENT. (You are not required to designate an Alternate Agent but you may do so. An Alternate Agent may make the same health care decisions as the designated Agent if the designated Agent is unable or unwilling to act as your Agent. If the Agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my Agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my Agent to make health care decisions for me as authorized by this document, who serve in the following order:

FIRST ALTERNATE AGENT

Agent Name: ______________________________________

Address: ___________________________
___________________________, ___ __________

Phone: Home: _______________ Work: _______________

SECOND ALTERNATE AGENT

Agent Name: ______________________________________

Address: ___________________________
___________________________, ___ __________

Phone: Home: _______________ Work: _______________

D. DURATION. I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my Agent continues to exist until the time I become able to make health care decisions for myself.

E. PRIOR DESIGNATIONS REVOKED. I revoke any prior Durable Power of Attorney for Health Care.

F. ACKNOWLEDGEMENT OF DISCLOSURE STATEMENT. I have been provided with a Disclosure Statement explaining the effect of this Durable Power of Attorney document. I have read and understand that information contained in the Disclosure Statement.

III. SEVERABILITY

If any provision of this document is held to be invalid, such invalidity shall not affect the other provisions which can be given effect without the invalid provision, and to this end the directions in this document are severable.

(YOU MUST DATE AND SIGN THIS DOCUMENT)

I sign my name to this Document on _____ day of ____________________, _____, at __________________________, ___.

Signature: ____

Name: ________________________

STATEMENT OF WITNESSES

I declare under penalty of perjury that __________ has identified himself or herself to me, that _______________ signed or acknowledged this Document in my presence, that I believe _____________________ to be of sound mind, that _______________ has affirmed that ________________ is aware of the nature of the document and is signing it voluntarily and free from duress, that ______________ requested that I serve as a witness to _________________'s execution of this document, that I am not the person appointed as Agent by this document, and that I am not a provider of health or residential care, an employee of a provider of health or residential care, the operator of a community care facility, or an employee of an operator of a health care facility. I am not an officer, director, partner, or business office employee of a health care facility or of any parent organization of a health care facility where ________________ is a patient.

I declare that I am not related to ______________ by blood, marriage, or adoption and that to the best of my knowledge I am not entitled to any part of the estate of ______________________ upon the death of Shorty under a will or by operation of law.

Witness Signature: ____

Name: ________________________________
Address: ________________________________
____

Date: _________________________

Witness Signature: ____

Name: ________________________________
Address: ________________________________
____

Date: ________________________

Subscribed and acknowledged before me by _______________, and subscribed and sworn to before me by the said _____________________, and_____________________, witnesses, this ____________ day of _________________, 20___.

____
NOTARY PUBLIC IN AND FOR
_______________________ COUNTY OF TEXAS

Final Checklist for Living Will, Health Care Power of Attorney, Advance Directive for Health Care

For: Shorty
January 20, 2013

Make It Legal

_____ You must be an an adult (18 in most states) and mentally competent to execute a valid document. The document must be signed and dated in order to be effective.

_____ You should sign this document in the presence of two witnesses who then sign the document in your presence and in each other's presence.

_____ The specific requirements for who can be a witness, whether the document must be notarized, and other execution formalities are printed on the document itself. THESE ARE SPECIFIC TO YOUR STATE AND MUST BE READ CAREFULLY AND COMPLIED WITH TO HELP ENSURE YOU HAVE A VALID DOCUMENT.

_____ You should initial on the bottom margin of each page of the document. This prevents the subsequent substitution of pages. To print out an initials line at the bottom of each page of your document, go to the "View" menu at the top of the screen and choose "Preferences." Select the "Print" tab and choose the appropriate checkbox.

_____ An indication should be made on the document itself regarding who has received a copy, in case there is a need for later retrieval, modification, or revocation.

Copies

* Give a signed copy of the document to:

  _____ Your health care provider(s), including your physician and any hospital where you are treated

  _____ Appropriate family members, a close friend, or clergy

  _____ ____________________________________ (your Agent)

* You should retain the original or a copy of the document for your own records.

When to Consult a Lawyer

* The document may not be valid in your state of residence unless that state was selected in the program. A lawyer should be consulted if there is any uncertainty regarding which state's document to use.

* Before signing the document, you should be completely comfortable that you understand the nature and range of decisions that may be made on your behalf. You should discuss the range of medical decisions with a physician, another health care provider, social worker, pastor, or a lawyer -- someone who is knowledgeable about these issues and can answer questions.

Other Information

* While each state has its own restrictions on who may be a witness, in general, persons should not be used as a witness if they have been appointed as your Agent in the directive; are your relative by blood, marriage, or adoption; are or may become directly involved in providing health care to you; are an employee of your health care provider; or are less than 18 years of age.

* You should discuss the document and your wishes with any person you want to designate as an Agent before doing so to assure they agree to act on your behalf.

* If you learn that you have a terminal condition after signing a health care directive, execute a new Directive. This will provide an opportunity to restate or change your

wishes in light of your new health status.

Reasons to Update

* Change or set limits on the medical care that is provided.
* Respond to a changing medical technology.
* Respond to a change in health care laws.
* Respond to a change in health, including pregnancy.
* Designate a different person to make health care decisions for you.