Legal Note: **The Documents here are provided for your information and that of your immediate family only. You are not permitted to copy any document provided to you. Each of these Documents provided are intended as general assistance in simple legal matters only. No document is intended to be used for any item, transaction, or other matter, where the total value of the item, transaction or matter is worth more than $ 5,000.00. You are not authorized to use any document for any transaction which is in excess of $ 5,000.00 in value or is not a simple matter. As a guideline to the meaning of simple, consider the following: if you can complete the document without any questions, it is likely a simple matter. However, if you need to ask any questions, you should consult with your Plan attorney. Do not speculate about completion of the blanks in this matter.**

The information provided in the documents, and the instructions provided with each document are not intended to constitute legal advice. These documents are intended to assist consumers in protecting themselves in certain simple transactions, without incurring expensive attorneys fees. If you need legal advice, Plan Attorneys will be happy to provide a free legal consultation, at no cost, to you as a Plan member. Understand that if you contact a Plan Attorney, he/she may not advise you as to how to complete your documents. They may only be retained to prepare documents for you which they deem to be proper in your situation.

Certain documents can be completed with either a pen or a typewriter, unless indicated otherwise in the specific instructions. **You should not make changes or alterations to any documents, once you have completed the document.** You must complete a new document fully, even if you wish to make any changes, even a small change. If you make any changes to a document, you cannot be sure that the change conforms to legal requirements. For example, changes to a will, in some circumstances, may void the entire will, even if you intended to make the changes. Thus, it is a safer practice to make a new document, if you intend to make any changes.

If there are blanks which are not used or which contain no information, place an X, or a line through the blank. This ensures that no person can make unauthorized modifications to a document, by simply completing the blanks, and changing the entire crux of the document.

Certain documents may require a notary. Notaries are certified by each state, and can only operate in the states in which they are licensed to operate. An invalid notary may invalidate your document. Notaries serve the purpose of verifying that the signature of the person signing the document, is in fact, the person claiming to have signed the document. Certain institutions require a notary, even when state law does not. Be sure to check with the parties with whom you are dealing to see if they will require a notary. Banks often require notaries.

If you believe that you must record a document, you should consult with a Plan Attorney. No document provided here is intended for recording, and any such document must be prepared by a Plan Attorney. We have not included certain documents, despite repeated requests, because these documents require the skill and expertise of an attorney. These include trusts, deeds, Mortgages, Escrow Agreements and other documents. Always consult a Plan Attorney before drafting one of these documents on your own.

DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS
WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTH CARE. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR ATTORNEY-IN-FACT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENTS OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE CONSENT, REFUSAL OF CONSENT, OR WITHDRAWAL OF CONSENT TO ANY CARE, TREATMENT, SERVICE, OR PROCEDURE TO MAINTAIN, DIAGNOSE, OR TREAT A PHYSICAL OR MENTAL CONDITION. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT OR PLACEMENTS THAT YOU DO NOT DESIRE.

2. THE PERSON YOU DESIGNATE IN THIS DOCUMENT HAS A DUTY TO ACT CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN , TO ACT IN YOUR BEST INTERESTS.

3. EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THE POWER OF THE PERSON YOU DESIGNATE TO MAKE HEALTH CARE DECISIONS FOR YOU MAY INCLUDE THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT WHICH WOULD KEEP YOU ALIVE.

4. UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST INDEFINITELY FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTH CARE DECISIONS FOR YOURSELF.

5. 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, AND HEALTH CARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED IF YOU OBJECT.

6. YOU HAVE THE RIGHT TO REVOKE THE APPOINTMENT OF THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THAT PERSON OF THE REVOCATION ORALLY OR IN WRITING.

7. YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY GRANTED TO THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU BY NOTIFYING THE TREATING PHYSICIAN, HOSPITAL, OR OTHER PROVIDER OF HEALTH CARE ORALLY OR IN WRITING.

8. THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTH CARE DECISIONS FOR YOU HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

9. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

10. IF THEIR IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

1. DESIGNATION OF HEALTH CARE AGENT.

I,_____
(insert your name)

do hereby designate and appoint:

Name:_____

Address:_____

_____

Telephone Number:_____

as my attorney-in-fact to make health care decisions for me as authorized in this document.

(Insert the name and address of the person you wish todesignate as your attorney-in-fact to make health care decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact: (1) your treating provider of health care, (2) an employee of your treating provider of health care, (3)an operator of a community care or residential care facility.)

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document I intend to create a durable power of attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED.

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power and authority to make health care decisions for me before, or after my death, including: consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain diagnose, or treat a physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS.

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in fact's authority to give consent for or other restrictions you wish to place on your attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, the authority of my attorney-in-fact is subject to the following special provisions and limitation:

_____

_____

_____

_____

_____

5. DURATION

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

(Fill in expiration date if applicable)

I wish to have this power of attorney end on the following date: _____

6. STATEMENT OF DESIRES.

(With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.)

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness. I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strong about the following forms of treatment:

I ( ) do ( ) do not want cardiac resuscitation.
I ( ) do ( ) do not want mechanical respiration.
I ( ) do ( ) do not want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water).
I ( ) do ( ) do not want blood or blood products.
I ( ) do ( ) do not want any form of surgery or invasive diagnostic tests.
I ( ) do ( ) do not want kidney dialysis.
I ( ) do ( ) do not want antibiotics.

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Other/Additional Statements of Desires: _____

_____

_____

_____

_____

7. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT.

(You are not required to designate any alternative attorney- in-fact but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1,page 2, in the event that he or she is unable or unwilling to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternative Attorney-in-fact

Name: _____

Address: _____

_____

Telephone Number: _____

B. Second Alternative Attorney-in-fact

Name: _____

Address: _____

_____

Telephone: _____

8. PRIOR DESIGNATIONS REVOKED. I revoke any durable power of attorney for health care

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Durable Power of Attorney for Health Care on _____
(date)

at _____ , _____
(city) (state)

_____
(Signature)

(THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2)ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of the statement of witnesses.)

STATE OF
COUNTY OF _____

Subscribed, sworn to and acknowledged before me by _____, the declarant, and subscribed and sworn to before me by _____ and _____, witnesses, the _____ day of _____, 19_____.

_____
Notary Public My Commission Expires:_____

STATEMENT OF WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized you must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the attorney-in-fact, (2) a provider of health care, (3) an employee of a provider of health care, (4) the operator of health care facility, (5) an employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury under the laws of _____ that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principle 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 provider of health care, an employee of a provider of health care, the operator of a community care facility, nor an employee of an operator of a health care facility.

Signature: _____
Print Name:_____
Residence Address: _____
_____
Date: _____

Signature: _____
Print Name:_____
Residence Address: _____
_____
Date: _____

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I declare under penalty of perjury under the laws of _____ (state), 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:_____
Residence Address: _____
_____
Date: _____

COPIES:You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be available so a copy may be given to your providers of health care.

Warning: This form is valid in 20 states.