~ Georgia ~

Durable Power of Attorney for Health Care Christian Version

NOTICE TO PERSON MAKING THIS DOCUMENT

NOTICE: THE PURPOSE OF THIS POWER OF ATTORNEY IS TO GIVE THE PERSON YOU DESIGNATE (YOUR AGENT) BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU, INCLUDING POWER TO REQUIRE, CONSENT TO, OR WITHDRAW ANY TYPE OF PERSONAL CARE OR MEDICAL TREATMENT FOR ANY PHYSICAL OR MENTAL CONDITION AND TO ADMIT YOU TO OR DISCHARGE YOU FROM ANY HOSPITAL, HOME, OR OTHER INSTITUTION; BUT NOT INCLUDING PSYCHOSURGERY, STERILIZATION, OR INVOLUNTARY HOSPITALIZATION OR TREATMENT COVERED BY TITLE 37 OF THE OFFICIAL CODE OF GEORGIA ANNOTATED. THIS FORM DOES NOT IMPOSE A DUTY ON YOUR AGENT TO EXERCISE GRANTED POWERS; BUT, WHEN A POWER IS EXERCISED, YOUR AGENT WILL HAVE TO USE DUE CARE TO ACT FOR YOUR BENEFIT AND IN ACCORDANCE WITH THIS FORM. A COURT CAN TAKE AWAY THE POWERS OF YOUR AGENT IF IT FINDS THE AGENT IS NOT ACTING PROPERLY. YOU MAY NAME COAGENTS AND SUCCESSOR AGENTS UNDER THIS FORM, BUT YOU MAY NOT NAME A HEALTH CARE PROVIDER WHO MAY BE DIRECTLY OR INDIRECTLY INVOLVED IN RENDERING HEALTH CARE TO YOU UNDER THIS POWER.

UNLESS YOU EXPRESSLY LIMIT THE DURATION OF THIS POWER IN THE MANNER PROVIDED BELOW OR UNTIL YOU REVOKE THIS POWER OR A COURT ACTING ON YOUR BEHALF TERMINATES IT, YOUR AGENT MAY EXERCISE THE POWERS GIVEN IN THIS POWER THROUGHOUT YOUR LIFETIME, EVEN AFTER YOU BECOME DISABLED, INCAPACITATED, OR INCOMPETENT. THE POWERS YOU GIVE YOUR AGENT, YOUR RIGHT TO REVOKE THOSE POWERS, AND THE PENALTIES FOR VIOLATING THE LAW ARE EXPLAINED MORE FULLY IN CODE SECTIONS 31-36-6, 31-36-9, AND 31-36-10 OF THE GEORGIA/DURABLE POWER OF ATTORNEY FOR HEALTH CARE ACT, OF WHICH THIS FORM IS A PART. THAT ACT EXPRESSLY PERMITS THE USE OF ANY DIFFERENT FORM OF POWER OF ATTORNEY YOU MAY DESIRE.

IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

GEORGIA STATUTORY SHORT FORM DURABLE POWER OF ATTORNEY FOR HEALTH CARE

This type of document has been authorized by the Georgia Code § 31-36-10

DURABLE POWER OF ATTORNEY made this _____ day of _____, _____.
Date Month Year

DESIGNATION OF HEALTH CARE AGENT

I, _____, _____
Name of principal Address

hereby appoint _____, _____
Health care agent Address

_____, (_____) _____, as my attorney in fact (my agent) to act for me and in my
Phone
name in any way I could act in person to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and health care and to require, withhold, or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to make a disposition of any part or all of my body for medical purposes, authorize an autopsy of my body, and direct the disposition of my remains.

THE ABOVE GRANT OF POWER IS INTENDED TO BE AS BROAD AS POSSIBLE SO THAT YOUR AGENT WILL HAVE AUTHORITY TO MAKE ANY DECISIONS YOU COULD MAKE TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF NOURISHMENT AND FLUIDS AND OTHER LIFE–SUSTAINING OR DEATH– DELAYING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT'S POWERS OR PRESCRIBE SPECIAL RULES TO LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY, OR DISPOSE OF REMAINS, YOU MAY DO SO ON THE FOLLOWING PAGE.

STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS

The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as your own definition of when life–sustaining or death–delaying measures should be withheld; a direction to continue nourishment and fluids or other life–sustaining or death–delaying treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electroconvulsive therapy, or amputation):

_____

_____

WITHHOLDING OR REMOVAL OF LIFE–SUSTAINING OR DEATH–DELAYING TREATMENT

The subject of life–sustaining or death–delaying treatment is of particular importance. For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life–sustaining or death–delaying treatment are set forth below. If you agree with one of these statements, you may initial that statement, but *do not initial more than one*:

I do not want my life to be prolonged nor do I want life–sustaining or death–delaying treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved, and the quality as well as the possible extension of my life in making decisions concerning life–sustaining or death–delaying treatment.

Initialed_____

I want my life to be prolonged and I want life–sustaining or death–delaying treatment to be provided or continued unless I am in a coma, including a persistent vegetative state, which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered such an irreversible coma, I want life–sustaining or death–delaying treatment to be withheld or discontinued.

Initialed_____

I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery, or the cost of the procedures.

Initialed_____

DURATION

This power of attorney may be amended or revoked by you at any time and in any manner while you are able to do so. In the absence of an amendment or revocation, the authority granted in this power of attorney will become effective at the time this power is signed and will continue until your death and will continue beyond your death if anatomical gift, autopsy, or disposition of remains is authorized, unless a limitation on the beginning date or duration is made by initialing and completing either or both of the following:

( ) This power of attorney shall become effective on _____
(insert a future date or event during your lifetime, such as court determination of your disability, incapacity, or incompetency, when you want this power to first take effect).

( ) This power of attorney shall terminate on _____
(insert a future date or event, such as court determination of your disability, incapacity, or incompetency, when you want this power to terminate prior to your death).

DESIGNATION OF SUCCESSOR AGENTS

If you wish to name successor agents, insert the names and addresses of such successors in the following paragraph.

If any agent named by me shall die, become legally disabled, incapacitated, or incompetent, or resign, refuse to act, or be unavailable, I name the following (each to act successively in the order named) as successors to such agent:

1st successor agent

_____ Phone: (_____) _____
Name of successor agent

_____
Street

_____, _____, _____
City State Zip Code

2nd successor agent

_____ Phone: (_____) _____
Name of successor agent

_____
Street

_____, _____, _____
City State Zip Code

GUARDIAN OF PERSON

If you wish to name a guardian of your person in the event a court decides that one should be appointed, you may, but are not required to, do so by inserting the name of such guardian in the following paragraph. The court will appoint the person nominated by you if the court finds that such appointment will serve your best interests and welfare. You may, but are not required to, nominate as your guardian the same person named in this form as your agent.

If a guardian of my person is to be appointed, I nominate the following to serve as such guardian:

_____ Phone: (_____) _____
Name of guardian of your person

_____
Street

_____, _____, _____
City State Zip Code

STATEMENT OF PRINCIPAL

I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signature✎_____
Principal

STATEMENT OF WITNESSES

The principal has had an opportunity to read the above form and has signed the above form in our presence. We, the undersigned, each being over 18 years of age, witness the principal's signature at the request and in the presence of the principal, and in the presence of each other, on the day and year above set out.

Witness #1

Print name: _____ Date: _____

Address: _____

Signature✎_____

Witness #2

Print name: _____ Date: _____

Address: _____

Signature✎_____

Additional witness required when health care agency is signed in a hospital or skilled nursing facility

ADDITIONAL WITNESS

I hereby witness this health care agency and attest that I believe the principal to be of sound mind and to have made this health care agency willingly and voluntarily.

Attending Physician as Additional Witness

Print name: _____ Date: _____

Address: _____

Signature✎_____

SPECIMEN SIGNATURES

YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.

Specimen signatures of agent and successor(s).

✎_____
Agent

✎_____
Successor agent

✎_____
Successor agent

I certify that the signature of my agent and successor(s) are correct.

✎_____
Principal

✎_____
Principal

✎_____
Principal

STATEMENT OF HEALTH CARE AGENT AND SUCCESSOR HEALTH CARE AGENT(S)

I understand that _____ has designated me to be his or her health care agent
Name of principal
or successor health 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.

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

Agent's signature ✎_____

Address: _____

First successor's signature ✎_____

Address: _____

Second successor's signature ✎_____

Address: _____

<u>REMINDER</u>: KEEP THE SIGNED ORIGINAL WITH YOUR PERSONAL PAPERS. GIVE SIGNED COPIES TO YOUR DOCTORS, FAMILY, AND AGENT(S).

A PHOTOCOPY OF THIS DOCUMENT SHALL BE DEEMED AS VALID AS THE ORIGINAL.

ADDENDUM TO THE STATE OF GEORGIA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

GENERAL STATEMENT OF AUTHORITY GRANTED

As the declarant of this document, I desire to have my health care decisions made in accordance with this Addendum to the Durable Power of Attorney for Health Care. The purposes of this Addendum are to provide a witness to my Christian belief that life is a gift from God, and to provide direction for my agent to make decisions that are consistent with my Christian faith.

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care agent 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 health care agent under this document.

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

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 health care 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 health care agent has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my health care 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 health care 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 health care 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, this condition must be diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition. Upon such diagnosis, my health care agent may consent to the withholding or withdrawal of certain life–sustaining health care, remaining faithful to the directives found in the rest of this document. 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 health care 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 health care agent may not have a feeding tube withheld or withdrawn from me.

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

PREGNANT WOMEN

If I am pregnant, the following applies:

1. My health care 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 health care 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 health care agent may not make health care decisions for me if my health care 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 health care agent may not make health care decisions for me if he or she knows I am pregnant.

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

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

Subject to any limitations in this document, my health care agent 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.

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 heath information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

ADMISSION TO NURSING HOMES OR COMMUNITY–BASED RESIDENTIAL FACILITIES

My health care agent may admit me to a nursing home or community–based residential facility for short–term stays for recuperative care or respite care.

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

1. A nursing home ➧ **Yes** ❑ **No** ❑

2. A community–based residential facility ➧ **Yes** ❑ **No** ❑

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

The principal and the witnesses must sign the document at the same time

SIGNATURE OF PRINCIPAL

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

Signature✎_____ Date: _____

(The signing of this document by the principal revokes all previous powers of attorney for health care documents)

The State of Georgia provides for the principal's signature to be witnessed by two individuals as specified below. In addition, if at the time a health care agency is executed the principal is a patient in a hospital or skilled nursing facility, the health care agency shall also be attested to and subscribed in the presence of the principal by the principal's attending physician.

STATEMENT OF WITNESSES

The principal has had an opportunity to read the above form and has signed the above form in our presence. We, the undersigned, each being over 18 years of age, witness the principal's signature at the request and in the presence of the principal, and in the presence of each other, on the day and year above set out.

Witness #1

Print name: _____ Date: _____

Address: _____

Signature✎_____

Witness #2

Print name: _____ Date: _____

Address: _____

Signature✎_____

Additional witness required when health care agency is signed in a hospital or skilled nursing facility

ADDITIONAL WITNESS

I hereby witness this health care agency and attest that I believe the principal to be of sound mind and to have made this health care agency willingly and voluntarily.

Attending Physician as Additional Witness

Print name: _____ Date: _____

Address: _____

Signature✎_____

STATEMENT OF HEALTH CARE AGENT AND SUCCESSOR HEALTH CARE AGENT(S)

I understand that _____ has designated me to be his or her health care agent
Name of principal
or successor health 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.

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

Agent's signature ✎_____

Address: _____

First successor's signature ✎_____

Address: _____

Second successor's signature ✎_____

Address: _____

PASTOR
Optional

Pastor's signature ✎_____ Phone: (_____) _____

Church name: _____

Address: _____

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

_____

_____

_____

_____

_____

_____