THIS POWER OF ATTORNEY FOR PERSONAL CARE is given by , of the City of Toronto, in the Province of Ontario.

1. I REVOKE any previous power of attorney for personal care made by me and APPOINT my , to be my attorney for personal care in accordance with the *Substitute Decisions Act*, 1992.

2. If my said cannot or will not be my attorney because of refusal, resignation, death, mental incapacity or removal by the court, I SUBSTITUTE and APPOINT , to be my attorney[s] for personal care in the same manner and subject to the same authority as whom [he/she is] [they are] replacing. [If one of my attorneys dies or becomes incapable of acting as my attorney, I appoint the attorney remaining capable to act in such capacity alone to be my attorney for personal care in the same manner and subject to the same authority as the attorneys whom he is replacing.] The expression "attorney" used throughout this power of attorney for personal care shall mean the attorney or attorneys hereunder for the time being, whether original or substituted.

3. I GIVE my attorney the authority to make any personal care decision for me that I am mentally incapable of making for myself during periods when (i) I am not able to understand information that is relevant to making a decision concerning my own health care, nutrition, shelter, clothing, hygiene or safety, or (ii) I am not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision with respect to my own health care, nutrition, shelter, clothing, hygiene or safety, or (iii) I have been found to be legally incapable of personal care; and in any such event this authority includes the power to give or refuse consent to treatment to which the *Health Care Consent Act*, 1996 applies.

4. If at any time I should have a terminal condition and if my attending physician has determined that there can be no reasonable expectation of recovery from such condition and that my death is imminent, I DIRECT that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care or to alleviate pain.

5. In making this power of attorney, I CONFIRM that I am at least sixteen years of age and am capable of giving this power of attorney for personal care because I am aware:

   (a) that my attorney has a genuine concern for my welfare; and

(b) that I may need my attorney to make personal care decisions for me.

I have signed this power of attorney in the presence of both of the witnesses whose names appear below on the day of , 200 .

_____
Name

We are the witnesses to this power of attorney. We have signed this power of attorney in the presence of the person whose name appears above, and in the presence of each other, on the date shown above. Neither one of us is the attorney, a spouse or partner of the attorney, a spouse or partner of the grantor, a child of the grantor or a person whom the grantor has demonstrated a settled intention to treat as a child of the grantor, a person whose property is under guardianship or who has a guardian of the person, or less than eighteen years old. We acknowledge that to be capable of giving a power of attorney for personal care the person must meet the requirements of paragraph 5 of this power of attorney. We have reviewed each of these requirements with the person whose name appears above and we have no reason to believe that such person is incapable of giving this power of attorney for personal care or making the decisions in respect of which instructions are contained in this power of attorney.

_____	_____
Witness Signature	Witness Signature
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____