DISTRICT OF COLUMBIA POWER OF ATTORNEY FOR HEALTH CARE

INFORMATION ABOUT THIS DOCUMENT

This is an important legal document. Before signing this document, it is vital for you to know and understand these facts:

This document gives the person you name as your attorney in fact the power to make health-care decisions for you if you cannot make the decisions for yourself.

After you have signed this document, you have the right to make health care decisions for yourself if you are mentally competent to do so. In addition, after you have signed this document, no treatment may be given to you or stopped over your objection if you are mentally competent to make that decision.

You may state in this document any type of treatment that you do not desire and any that you want to make sure you receive.

You have the right to take away the authority of your attorney in fact, unless you have been adjudicated incompetent, by notifying your attorney in fact or health-care provider either orally or in writing. Should you revoke the authority of your attorney in fact, it is advisable to revoke in writing and to place copies of the revocation wherever this document is located.

If there is anything in this document that you do not understand, you should ask a social worker, lawyer or other person to explain it to you.

You should keep a copy of this document after you have signed it. Give a copy to the person you name as your attorney in fact. If you are in a health-care facility, a copy of this document should be included in your medical record.

INSTRUCTIONS

DISTRICT OF COLUMBIA POWER OF ATTORNEY FOR HEALTH CARE

PRINT YOUR NAME AND ADDRESS

I, _____, of
(name)

_____,hereby appoint:
(home address)

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR ATTORNEY IN FACT

_____
(name of attorney-in-fact)

_____
(home address)

_____
(work telephone number) *(home telephone number)*

as my attorney in fact to make health-care decisions for me if I become unable to make my own health-care decisions. This gives my attorney in fact the power to grant, refuse, or withdraw consent on my behalf for any health-care service, treatment or procedure. My attorney in fact also has the authority to talk to health-care personnel, get information and sign forms necessary to carry out these decisions.

If the person named as my attorney in fact is not available or is unable to act as my attorney in fact, I appoint the following person(s) to serve in the order listed below:

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST AND SECOND ALTERNATE ATTORNEY IN FACT

1. _____
(name of first alternate attorney in fact)

_____
(home address)

_____
(work telephone number) *(home telephone number)*

2. _____
(name of second alternate attorney in fact)

_____
(home address)

_____
(work telephone number) *(home telephone number)*

With this document, I intend to create a power of attorney for health care, which shall take effect if I become incapable of making my own health-care decisions and shall continue during that incapacity.

My attorney in fact shall make health-care decisions as I direct below or as I make known to my attorney in fact in some other way.

ADD PERSONAL INSTRUCTIONS (IF ANY)

Statement of directives concerning life-prolonging care, treatment, services and procedures:

ADD LIMITATIONS ON YOUR ATTORNEY IN FACT'S POWER (IF ANY)

Special provisions and limitations:

PRINT THE DATE AND YOUR LOCATION AND SIGN THE DOCUMENT

By my signature I indicate that I understand the purpose and effect of this document.

I sign my name to this form on _____
(date)

at: _____
(address of location)

_____
(signature)

YOUR WITNESSES MUST SIGN THE DOCUMENT ON THE NEXT PAGE

WITNESSING PROCEDURE

WITNESSES MUST SIGN AND DATE THE DOCUMENT AND PRINT THEIR NAMES AND ADDRESSES

WITNESSES

I declare that the person who signed or acknowledged this document is personally known to me, that the person signed or acknowledged this durable power of attorney for health care in my presence, and that the person appears to be of sound mind and under no duress, fraud, or undue influence. I am not the person appointed as the attorney in fact by this document, nor am I the health-care provider of the principal or an employee of the health-care provider of the principal.

WITNESS #1

First Witness' Signature: _____

Home Address: _____

Print Name: _____

Date: _____

WITNESS #2

Second Witness' Signature: _____

Home Address: _____

Print Name: _____

Date: _____

ONE OF YOUR WITNESSES MUST ALSO AGREE WITH THIS STATEMENT AND SIGN BELOW

(AT LEAST 1 OF THE WITNESSES LISTED ABOVE SHALL ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare 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 under a currently existing will or by operation of law.

Signature: _____

Signature: _____

INSTRUCTIONS

DISTRICT OF COLUMBIA DECLARATION

PRINT THE DATE

Declaration made this _____ day of _____.
(date) *(month, year)*

PRINT YOUR NAME

I, _____,
(name)

being of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, do declare:

If at any time I should have an incurable injury, disease or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, 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.

ADD PERSONAL INSTRUCTIONS (IF ANY)

Other directions:

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration 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.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

SIGN THE DOCUMENT AND PRINT YOUR ADDRESS

Signed _____

Address _____

_____

WITNESSING PROCEDURE

WITNESSES MUST SIGN BELOW

I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am at least eighteen years of age and am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession of the District of Columbia or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not the declarant's attending physician, an employee of the attending physician, or an employee of the health facility in which the declarant is a patient.

WITNESS #1

Witness _____

WITNESS #2

Witness _____