Principal Name: ________________________________

Health Care Power of Attorney

(Please refer to the Health Care Power of Attorney Toolkit for instructions to complete this worksheet.)

1. Assign Health Care Agent(s).

I, ________________________________, appoint

Name:____

Address:____

Home Phone # ____

Work Phone #____

as my health care attorney-in-fact (herein referred to as my "health care agent") to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document.

If the person named as my health care agent is not reasonably available or is unable or unwilling to act as my agent, then I appoint the following persons (each to act alone and successively, in the order named), to serve in that capacity: (Optional)

Name:____

Address:____

Home Phone # ____

Work Phone #____

If the preceding persons named as my health care agent are not reasonably available or is unable or unwilling to act as my agent, then I appoint the following persons (each to act alone and successively, in the order named), to serve in that capacity: (Optional)

Name:____

Address:____

Home Phone # ____

Work Phone #____

2. Designate Physicians for Crisis Evaluation. I wish the following doctor to evaluate whether I lack sufficient understanding to make or communicate treatment decisions:

Name:____

Home Phone # ____

Work Phone #____

3. Grant Authorities to Health Care Agent. Below, my initial signifies I grant the following powers to my Health Care Agent:

______ A. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records, and to consent to the disclosure of this information.

______ B. To employ or discharge my health care providers.

______ C. To consent to and authorize my admission to and discharge from a hospital, nursing or convalescent home, or other institution.

______ D. To consent to and authorize my admission to and retention in a facility for the care or treatment of mental illness.

______ E. To consent to and authorize the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment".

______ F. To give consent for, to withdraw consent for, or to withhold consent for, X ray, anesthesia, medication, surgery, and all other diagnostic and treatment procedures ordered by or under the authorization of a licensed physician, dentist, or podiatrist. This authorization specifically includes the power to consent to measures for relief of pain.

______ G. To authorize the withholding or withdrawal of life-sustaining procedures when and if my physician determines that I am terminally ill, permanently in a coma, suffer severe dementia, or am in a persistent vegetative

state. Life-sustaining procedures are those forms of medical care that only serve to artificially prolong the dying process and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of medical treatment which sustain, restore or supplant vital bodily functions. Life-sustaining procedures do not include care necessary to provide comfort or alleviate pain.

______ H. To exercise any right I may have to make a disposition of any part or all of my body for medical purposes, to donate my organs, to authorize an autopsy, and to direct the disposition of my remains.

______ I. To take any lawful actions that may be necessary to carry out these decisions, including the granting of releases of liability to medical providers.

4. Special Provisions. The health care agent is subject to the following limitations when making decisions about my:

A. Physical Health

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B. Mental Health

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5. Provision on Guardianship. My initial here signifies I would like to nominate your health care agent as a guardian, should the need arise: _______

6. Legal Documentation

A. Miscellaneous Provisions

1. I revoke any prior health care power of attorney.
2. My health care agent shall be entitled to sign, execute, deliver, and acknowledge any contract or other document that may be necessary, desirable, convenient, or proper in order to exercise and carry out any of the powers described in this document and to incur reasonable costs on my behalf incident to the exercise of these powers; provided, however, that except as shall be necessary in order to exercise the powers described in this document relating to my health care, my health care agent shall not have any authority over my property or financial affairs.
3. My health care agent and my health care agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, my heirs, successors, and assigns and personal representatives from all liability and

from all claims or demands of all kinds arising out of the acts or omissions of my health care agent pursuant to this document, except for willful misconduct or gross negligence.

4. No act or omission of my health care agent, or of any other person, institution, or facility acting in good faith in reliance on the authority of my health care agent pursuant to this health care power of attorney shall be considered suicide, nor the cause of my death for any civil or criminal purposes, nor shall it be considered unprofessional conduct or as lack of professional competence. Any person, institution, or facility against whom criminal or civil liability is asserted because of conduct authorized by this health care power of attorney may interpose this document as a defense.

B. Signature

By signing here, I indicate that I am mentally alert and competent, fully informed as to the contents of this document, and understand the full import of this grant of powers to my health care agent.

Signature of Principal__________________________________

Date ___________________ (SEAL)

C. Witnesses

I hereby state that the Principal, ____________________________________, being of sound mind, signed the foregoing health care power of attorney in my presence, and that I am not related to the principal by blood or marriage, and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor an employee of the principal's attending physician, nor an employee of the health facility in which the principal is a patient,

nor an employee of a nursing home or any group care home where the principal resides. I further state that I do not nave any claim against the principal.

Witness: ___________________________ Date: __________________

Witness: ___________________________ Date: __________________

D. Notarization

STATE OF NORTH CAROLINA COUNTY OF _______________________

CERTIFICATE

I, _________________________________, a Notary Public for _________________ County, North Carolina, hereby certify that _______________________________ appeared before me and swore to me and to the witnesses in my presence that this instrument is a health care power of attorney, and that he/she willingly and voluntarily made and executed it as his/her free act and deed for the purposes expressed in it.

I further certify that ____________________________ and ___________________________, witnesses, appeared before me and swore that they witnessed _________________________ sign the attached health care power of attorney, believing him/her to be of sound mind; and also swore that at the time they witnessed the signing (i) they were not related within the third degree to him/her or his/her spouse, and (ii) they did not know nor have a reasonable expectation that they would be entitled to any portion of his/her estate upon his/her death under any will or codicil thereto then existing or under the Intestate Succession Act as it provided at that time, and (iii) they were not a physician attending him/her, nor an employee of an attending physician, nor an employee of a health facility in which he/she was a patient, nor an employee of a nursing home or any group-care home in which he/she resided, and (iv) they did

not have a claim against him/her. I further certify that I am satisfied as to the genuineness and due execution of the instrument.

This the __________ day of _______________, 20____.

____
Notary Public

My Commission Expires: _______________________________