DURABLE HEALTH CARE POWER OF ATTORNEY

It is important to choose someone to make healthcare decisions for you when you cannot direct your own care. These health care decisions should reflect your values, beliefs and preferences in light of your spiritual, emotional and physical needs. The person you choose has the moral and ethical responsibility to ensure your health care wishes are honored.
I, _____, as Principal, designate _____
as my agent.

_____ By initialing here, I specifically authorize my agent for matters related to my healthcare, including, and without limitation, to give or refuse consent to medical, surgical, hospital and related health care, and optionally mental health care decisions. This medical power of attorney is effective if I am unable to make or communicate my health care decisions. Once this power of attorney is effective, all my agent's actions under this power have the same effects on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself. This appointment is effective unless and until it is revoked by me or by an order of a court.

DURABLE MENTAL HEALTH CARE POWER OF ATTORNEY (optional)

_____ By initializing here, if I am incapable (as decided by an Arizona licensed psychiatrist or psychologist after evaluation), I specifically authorize my agent the power to do the following which I have initialed or marked:

_____ To receive information regarding my mental health treatment that is proposed for me and to receive, review and consent to disclosure of my medical records related to that treatment.

_____ To consent to the administration of any medications recommended by my treating physician.

_____ To admit me to an inpatient psychiatric hospitalization program if ordered by physician.

_____ To admit me in a partial psychiatric hospitalization program if ordered by my physician.

This appointment is effective unless and until it is revoked by me or by an order of a court.

PRINT AGENT NAME, ADDRESS, PHONE NUMBER(S)
Name: _____
Address: _____
Phone Number: _____ Cell Number: _____ Work Number: _____
If the above agent is unwilling or unable to serve or continue to serve, I hereby appoint the following person:
PRINT AGENT NAME, ADDRESS, PHONE NUMBER(S) (Optional)
Name: _____
Address: _____
Phone Number: _____ Cell Number: _____ Work Number: _____
Please Mark One: _____ I have _____ have not completed a living will on the reverse side of this form to provide specific direction to my agent. My agent is directed to follow these choices I have initiated in the living will.

THIS DOCUMENT MAY BE CHANGED ONLY BY THE PRINCIPAL WHILE COMPETENT.

Principal Signature _____Date:_____
Witness statement: I affirm I am at least 18 years of age, not related to the Principal, not financially connected to the Principal's estate and not responsible for directly administering the Principal's health care treatments. I further affirm I was present when this health care power of attorney was signed and dated. The Principal appeared to be of sound mind and free from duress.
Witness Signature _____ Date: _____

This document may be notarized instead of witnessed.

On this _____ day of _____ in the year of _____ personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS THEREOF, I have set my hand and affixed my official seal in the County of _____, State of _____ on the date written above.
Notary Public _____

LIVING WILL

I, _____, as principal, want my physicians and my family to consider all the dimensions of my being: spiritual, emotional and physical when following my health care directives. I direct those involved in my health care to implement my health care preferences, as indicated below, or by my health care surrogate or agent if I cannot speak for myself.
I want my doctors to provide holistic care and to help me maintain an acceptable quality of life, including adequate pain management, comfort care, and hospice as appropriate. To me an unacceptable quality of life is when I have any of the following conditions (check all that apply):
____ **Persistent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up due to chronic coma or persistent vegetative state.
____ **Permanent Confusion:** I become unable to remember, understand or make decisions. I do not recognize loved ones.
____ **Total or Near Dependence in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking.
____ **End-Stage Illness:** I have an illness that has reached its final stage.
____ **Other:**

INITIAL EITHER NUMBER 1 OR NUMBER 2 BUT NOT BOTH

1. _____ **Directive to Allow Natural Death:**
   a. If the treatments that my doctors suggest will not restore me from an unacceptable quality of life, as defined by me above, there are some procedures that **I do not want** so that I will be allowed to die naturally(indicate by initialing):
   _____ **CPR(Cardiopulmonary Resuscitation):** I do not want attempts made to restore my heart beat and my breathing after they have stopped and I have died.
   _____ **Artificial Ventilation:** I do not want continuous use of a breathing machine.
   _____ **Kidney Dialysis:** I do not want kidney dialysis.
   _____ I do not want **Medications** to keep lungs, heart, kidneys, and other organs working.
   _____ **Treatment of New Conditions:** I do not want use of surgery, blood transfusion, or antibiotics that will deal with a new illness/complication but will not change the course of the main illness.
   _____ **Tube Feeding/IV Fluids:** I do not want the use of tubes to deliver food/water to my stomach or IV fluids, which could include artificially delivered nutrition and hydration into my veins, if deemed medically futile.

_____ **Other:**

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   a. If the treatments that my doctors suggest will not restore me from an unacceptable quality of life, as defined by me above, there are some procedures that **I do not want** so that I will be allowed to die naturally(indicate by initialing):
   _____ **Comfort Care Only:** If I have a terminal condition I do not want my life to be prolonged and I do not want life-sustaining treatment beyond comfort care that would serve only to artificially delay the moment of my death.
   _____ **Treatment Until my Medical Condition is Reasonably Known:** Regardless of the directions I have made in this Living Will, I do not want all medical care necessary to treat my medical condition until my doctors and my agent reasonably conclude that my condition is such that treatment will not restore me from an unacceptable quality of life.

2. _____ **Directive to Sustain My Life:** I want my life to be prolonged to the greatest extent possible

Principal Signature _____Date:_____
Witness statement: I affirm I am at least 18 years of age, not related to the Principal, not financially connected to the Principal's estate and not responsible for directly administering the Principal's health care treatments. I further affirm I was present when this health care power of attorney was signed and dated. The Principal appeared to be of sound mind and free from duress.
Witness Signature _____ Date: _____

This document may be notarized instead of witnessed.

On this _____ day of _____ in the year of _____ personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS THEREOF, I have set my hand and affixed my official seal in the County of _____, State of _____ on the date written above.
Notary Public _____