INSTRUCTIONS

PRINT YOUR NAME AND ADDRESS

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

POWERS OF YOUR ATTORNEY-IN-FACT

INDIANA POWER OF ATTORNEY FOR HEALTH CARE DECISIONS AND APPOINTMENT OF HEALTH CARE REPRESENTATIVE

1) I, _____

(name)

of _____

(address)

hereby appoint _____

(name of attorney-in-fact)

_____

(address)

_____

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

as my attorney-in-fact to make health care decisions on my behalf whenever I am incapable of making my own health care decisions.

I grant my attorney-in-fact the following powers in matters affecting my health care:

(1) to employ or contract with servants, companions, or health care providers involved in my health care;
(2) to admit or release me from a hospital or health care facility;
(3) to have access to my records, including medical records;
(4) to make anatomical gifts on my behalf;
(5) to request an autopsy; and
(6) to make plans for the disposition of my body.

Provided by:

WOODLAWN HOSPITAL
ROCHESTER — INDIANA

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR ALTERNATE ATTORNEY-IN-FACT

2) In the event the person I appoint above is unable, unwilling or unavailable to act as my attorney-in-fact, I hereby appoint:

_____

(name of successor attorney-in-fact)

of _____

(address)

_____

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

as my successor attorney-in-fact.

APPOINTMENT AND POWERS OF HEALTH CARE REPRESENTATIVE

Appointment of my Attorney-in-Fact as my Health Care Representative

In addition to the powers granted above, I appoint my attorney-in-fact as my **health care representative** to make decisions in my best interest concerning the consent, withdrawal or withholding of health care. I understand health care to include any medical care, treatment, service, or procedure to maintain, diagnose, treat, or provide for my physical or mental well-being. Health care also includes the providing of nutrition and hydration through intravenous, gastrostomy or nasogastric tubes.

If at any time, based on my previously expressed preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is not or would not be beneficial, or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others, to the extent they are available.

PRINT YOUR NAME AND THE DATE

I, _____, the principal, sign my name to

this instrument this _____ day of _____, 20_____,
(date) *(month)* *(year)*

and do hereby declare to the undersigned witness that I sign it willingly, and I execute it as my free and voluntary act for the purposes herein expressed, and that I am eighteen years of age or older, of sound mind, and under no constraint or undue influence.

SIGN THE DOCUMENT

_____
(principal)

A NOTARY PUBLIC MUST COMPLETE THIS SECTION OF YOUR DOCUMENT

Subscribed and acknowledged before me by _____,

the principal, this _____ day of _____, 20_____.

_____
(notary public)

My Commission expires _____

(Drafted with the assistance of George G. Slater, J.D., Carmel, IN)

Courtesy of **Partnership for Caring, Inc.** 6/96
1620 Eye Street, NW Suite 202 Washington, DC 20006 800-989-9455

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