LOUSIANA ADVANCE DIRECTIVE
POWER OF ATTORNEY FOR HEALTH CARE

I, _____ (print full name) ,being of sound mind, do hereby designate

_____ (print full name) as my agent with full power and authority to make health care decisions for me including, but not limited to, a Declaration Concerning Life-Sustaining Procedures in the event I am unable to or choose not to make these decisions for myself. This Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity or other condition that makes an express revocation of my agent impossible or impractical. I also grant my agent the authority to qualify me for all government entitlements including, but not limited to, Medicaid, Medicare, and Supplemental Social Security.

_____ _____

SIGNATURE PRINT NAME

_____ _____

CITY, PARISH OF RESIDENCE STATE OF RESIDENCE

The declarant has been personally known to me and I believe him or her to be of sound mind.

_____ _____

WITNESS 1 SIGNATURE WITNESS 1 PRINT NAME

_____ _____

WITNESS 2 SIGNATURE WITNESS 2 PRINT NAME

Notarization of this form is optional.

Sworn and subscribed before me,

this _____day of _____, _____.

_____

Notary Public

#_____

My commission expires _____

DISCLAIMER: The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.

PROXIMITI HEALTH

America Living Will REGISTRY
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DECLARATION CONCERNING LIFE-SUSTAINING PROCEDURES

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

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

If at any time I should have an incurable injury, disease or illness, or be in a continual profound comatose state with no reasonable chance of recovery, certified to be a terminal and irreversible 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 procedure would serve only to prolong artificially the dying process, I direct (initial one only):

____ That all life-sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.

____ That life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

Other directions - Add any personal instructions related to health care.
_____
_____
_____
_____

I further direct 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.

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.

_____ _____

SIGNATURE PRINT NAME

_____ _____

CITY, PARISH OF RESIDENCE STATE OF RESIDENCE

The declarant has been personally known to me and I believe him or her to be of sound mind.

_____ _____

WITNESS 1 SIGNATURE WITNESS 1 PRINT NAME

_____ _____

WITNESS 2 SIGNATURE WITNESS 2 PRINT NAME

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