PROXIMITI HEALTH

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Part 1
Power Of Attorney For Health Care

(1) Designation of Agent: I designate the following individual as my agent to make health care decisions for me.

____
(Name of individual you choose as agent)

____
(Address) (City) (State) (Zip code)

____
(Home phone) (Work phone)

Optional: If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health care decision for me, I designate as my first alternate agent:

____
(Name of individual you choose as first alternate agent)

____
(Address) (City) (State) (Zip code)

____
(Home phone) (Work phone)

Optional: If I revoke the authority of my agent and first alternate or if neither is willing, able or reasonably available to make a health care decision for me, I designate as my second alternate agent:

____
(Name of individual you choose as second alternate agent)

____
(Address) (City) (State) (Zip code)

____
(Home phone) (Work phone)

(2) *Agent's Authority*: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

____
____
____

(add additional sheets if needed)

(3) *When Agent's Authority Becomes Effective*: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health care decisions for me takes effect immediately.

(4) *Agent's Obligation*: My agent shall make health care decisions for me in accordance with this Power of Attorney for Health Care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) *Nomination of Guardian*: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.
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Part 2
Instructions For Health Care

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) *End-of-life Decisions*: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

[ ] (a) **Choice Not To Prolong Life**
I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, or

[ ] (b) Choice to Prolong Life
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(7) *Artificial Nutrition and Hydration*: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box.
If I mark this box **[ ]**, artificial nutrition and hydration **must be provided** regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) *Relief from Pain:* Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:
____
____

(9) *Other Wishes:* (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.):
I direct that:
____

(Add any additional sheets if needed.)

Part 3
Primary Physician
(Optional)

(10) *I designate the following physician as my primary physician*:

____
(Name of physician)

____
(Address) (City) (State) (Zip code)

____
(Phone) (Phone)

Optional: If the physician I have designated above is not willing or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

____
(Name of physician)

____
(Address) (City) (State) (Zip code)

____
(Phone) (Phone)

(11) *Effect of Copy*: A copy of this form has the same effect as the original.

(12) *Signatures:* Sign and date the form here:

________________________________ ________________________________
(Date) (Sign your name)

________________________________ ________________________________
(Address) (Print your name)

____
(City) (State)

Part 4
Certificate of Authorization for Organ Donation
(Optional)

I, the undersigned, this ____________day of ___________, 20__, desire that my ___________________ ____organ(s) be made available after my demise for:

(a) Any licensed hospital, surgeon or physician, for medical education, research, advancement of medical science, therapy or transplantation to individuals;

(b) Any accredited medical school, college or university engaged in medical education or research, for therapy, educational research or medical science purposes or any accredited school or mortuary science;

(c) Any person operating a bank or storage facility for blood, arteries, eyes, pituitaries, or other human parts, for use in medical education, research, therapy or transplantation to individuals;

(d) The donee specified below, for therapy or transplantation needed by him or her, do donate my _________ for that purpose to ________________________________ (name) at ____(address).

I authorize a licensed physician or surgeon to remove and preserve for use my ______________________________________ for that purpose.

I specifically provide that this declaration shall supersede and take precedence over any decision by my family to the contrary.

Witnessed this ________ day of_____________________, 20______.

____
(donor)

____
(address)

____
(telephone)

____
(witness)

____
(witness)

(13) *Witnesses*: This Power of Attorney will not be valid for making health-care decisions unless it is either (a) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or (b) acknowledged before a notary public in the state.

Alternative No. 1

Witness 1:

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. 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 upon the death of the principal under a will now existing or by operation of law.

____

(Signature of witness) (Date)

____

(Printed name of witness)

____

(Street address City State Zip code)

Witness 2

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health-care provider or facility.

____

(Signature of witness) (Date)

____

(Printed name of witness) (Date)

____

(Street address City State Zip code)

Alternative No. 2
Notary

State of________________________________

County of ______________________________

On this the _______day of __________________, in the year______, before me,

______________________________________ (insert name of notary public) appeared

____ , personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

Notary Seal:

____

(Signature of Notary Public)

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.