DURABLE HEALTH CARE POWER OF ATTORNEYAND
HEALTH CARE TREATMENT INSTRUCTIONS (LIVING WILL)

PART I
INTRODUCTORY REMARKS ON HEALTH CARE DECISION MAKING

You have the right to decide the type of health care you want.

Should you become unable to understand, make or communicate decisions about medical care, your wishes for medical treatment are most likely to be followed if you express those wishes in advance by:

(1) naming a health care agent to decide treatment for you; and
(2) giving health care treatment instructions to your health care agent or health care provider.

An advance health care directive is a written set of instructions expressing your wishes for medical treatment.

NOTICE ABOUT ANATOMICAL DONATION

This document may also contain directions regarding whether you wish to donate an organ, tissue or eyes. Under Pennsylvania law, donating a part of the body for transplantation or research is a voluntary act. You do not have to donate an organ, tissue, eye or other part of the body. However, it is important that you make your wishes about anatomical donation known, just as it is important to make your choices about end-of-life care known.

Surgeons have made great strides in the field of organ donation and can now transplant hands, facial tissue and limbs. A hand, facial tissue and a limb are examples of what is known as a vascularized composite allograft. Under Pennsylvania law, explicit and specific consent to donate hands, facial tissue, limbs or other vascularized composite allografts must be given. You may use this document to make clear your wish to donate or not to donate hands, facial tissue or limbs.

Under Pennsylvania law, the organ donor designation on the driver's license authorizes the individual to donate what we traditionally think of as organs (heart, lung, liver, kidney) and tissue and does not authorize the individual to donate hands, facial tissue, limbs or other vascularized composite allografts.

Detailed information about anatomical donation, including the procedure used to recover organs, tissues and eyes, can be found on the Department of Transportation 's Internet website. Information about the donation of hands, facial tissue and limbs can also be found on the Department of Transportation's Internet website.

You may wish to consult with your physician or your attorney to determine whether the procedure for making an anatomical donation is compatible with fulfilling your specific choices

for end-of-life care. In addition, you may want to consult with clergy regarding whether you want to donate an organ, a hand, facial tissue or limb or other part of the body. It is important to understand that donating a hand, limb or facial tissue may have an impact on funeral arrangements and that an open casket may not be possible.

An advance health care directive may contain a health care power of attorney, where you name a person called a "health care agent" to decide treatment for you, and a living will, where you tell your health care agent and health care providers your choices regarding the initiation, continuation, withholding or withdrawal of .life-sustaining treatment and other specific directions regarding end-of-life care and your views regarding organ and tissue donation.

You may limit your health care agent's involvement in deciding your medical treatment so that your health care agent will speak for you only when you are unable to speak for yourself or you may give your health care agent the power to speak for you immediately. This combined form gives your health care agent the power to speak for you only when you are unable to speak for yourself. A living will cannot be followed unless your attending physician determines that you lack the ability to understand, make or communicate health care decisions for yourself and you are either permanently unconscious or you have an end-stage medical condition, which is a condition that will result in death despite the introduction or continuation of medical treatment. You, and not your health care agent, remain responsible for the cost of your medical care.

If you do not write down your wishes about your health care in advance, and if later you become unable to understand, make or communicate these decisions, those wishes may not be honored because they may remain unknown to others.

A health care provider who refuses to honor your wishes about health care must tell you of its refusal and help to transfer you to a health care provider who will honor your wishes.
You should give a copy of your advance health care directive (a living will, health care power of attorney or a document containing both) to your health care agent, your physicians, family members and others whom you expect would likely attend to your needs if you become unable to understand, make or communicate decisions about medical care. If your health care wishes change, tell your physician and write a new advance health care directive to replace your old one.
If your wishes about donating an organ, tissue or eyes change, tell your physician and write a new advance health care directive to replace your old one. If you do not wish to donate a hand, facial tissue or limb, it is important to make that clear in your advance health care directive or health care power of attorney, or both. It is important in selecting a health care agent that you choose a person you trust who is likely to be available in a medical situation where you cannot make decisions for yourself. You should inform that person that you have appointed him or her as your health care agent and discuss your beliefs and values with him or her so that your health care agent will understand your health care objectives, including whether you want to limit or withhold life-sustaining measures in the event that you become permanently unconscious or have an end-stage medical condition. You should also tell your health care agent whether you want to donate organs, tissue, eyes or other parts of the body and whether you want to make a donation of your hands, facial tissue or limbs. It is important to understand that if you decide to donate a hand, limb or facial tissue it may impact funeral arrangements and that an open casket may not be possible.

You may wish to consult with knowledgeable, trusted individuals such as family members, your physician or clergy when considering an expression of your values and health care wishes. You are free to create your own advance health care directive to convey your wishes regarding medical treatment. The following form is an example of an advance health care directive that combines a health care power of attorney with a living will.

NOTES ABOUT THE USE OF THIS FORM

If you decide to use this form or create your own advance health care directive, you should consult with your physician and your attorney to make sure that your wishes are clearly expressed and comply with the law.

If you decide to use this form but disagree with any of its statements, you may cross out those statements.

You may add comments to this form or use your own form to help your physician or health care agent decide your medical care.

This form is designed to give your health care agent broad powers to make health care decisions for you whenever you cannot make them for yourself. It is also designed to express a desire to limit or authorize care if you have an end-stage medical condition or are permanently unconscious. If you do not desire to give your health care agent broad powers, or you do not wish to limit your care if you have an end-stage medical condition or are permanently unconscious, you may wish to use a different form or create your own. YOU SHOULD ALSO USE A DIFFERENT FORM IF YOU WISH TO EXPRESS YOUR PREFERENCES IN MORE DETAIL THAN THIS FORM ALLOWS OR IF YOU WISH FOR YOUR HEALTH CARE AGENT TO BE ABLE TO SPEAK FOR YOU IMMEDIATELY. In these situations, it is particularly important that you consult with your attorney and physician to make sure that your wishes are clearly expressed, including whether you want to limit or withhold life-sustaining measures in the event that you become permanently unconscious or have an end-stage medical condition and whether you wish to donate a part of the body for transplantation or research. You should also clearly express whether or not you wish to donate hands, facial tissue or limbs.

This form allows you to tell your health care agent your goals if you have an end-stage medical condition or other extreme and irreversible medical condition, such as advanced Alzheimer's disease. Do you want medical care applied aggressively in these situations or would you consider such aggressive medical care burdensome and undesirable?

You may choose whether you want your health care agent to be bound by your instructions or whether you want your health care agent to be able to decide at the time what course of treatment the health care agent thinks most fully reflects your wishes and values.

If you are a woman and diagnosed as being pregnant at the time a health care decision would otherwise be made pursuant to this form, the laws of this Commonwealth prohibit implementation of that decision if it directs that life-sustaining treatment, including nutrition and hydration, be withheld or withdrawn from you, unless your attending physician and an obstetrician who have

examined you certify in your medical record that the life-sustaining treatment:

(1) will not maintain you in such a way as to permit the continuing development and live birth of the unborn child
(2) will be physically harmful to you; or
(3) will cause pain to you that cannot be alleviated by medication.

A physician is not required to perform a pregnancy test on you unless the physician has reason to believe that you may be pregnant.

Pennsylvania law protects your health care agent and health care providers from any legal liability for following in good faith your wishes as expressed in the form or by your health care agent's direction. It does not otherwise change professional standards or excuse negligence in the way your wishes are carried out. If you have any questions about the law, consult an attorney for guidance.

This form and explanation is not intended to take the place of specific legal or medical advice for which you should rely upon your own attorney and physician.

PART II
DURABLE HEALTH CARE POWER OF ATTORNEY

I, _____, of_____County, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me.

Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my health care agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the regulations promulgated thereunder and any other State or local laws and rules. Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by 45 C.F.R. Pt. 164.

The remainder of this document will take effect when and only when I lack the ability to understand, make or communicate a choice regarding a health or personal care decision as verified by my attending physician. My health care agent may not delegate the authority to make decisions.

MY HEALTH CARE AGENT HAS ALL OF THE FOLLOWING POWERS SUBJECT TO THE HEALTH CARE TREATMENT INSTRUCTIONS THAT FOLLOW IN PART III (CROSS OUT ANY POWERS YOU DO NOT WANT TO GIVE YOUR HEALTH CARE AGENT):

1. To authorize, withhold or withdraw medical care and surgical procedures.

2. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.

3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.

4. To hire and fire medical, social service and other support personnel responsible for my care.

5. To take any legal action necessary to do what I have directed.

6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.

7. To authorize or refuse to authorize donation of what we traditionally think of as organs (for example, heart, lung, liver, kidney), tissue, eyes or other parts of the body.

8. To authorize or refuse to authorize donation of hands, facial tissue, limbs or other vascularized composite allografts.

APPOINTMENT OF HEALTH CARE AGENT

I appoint the following health care agent:

Health Care Agent: _____
(Name and relationship)

Address: _____

Telephone Number: Home_____Work_____

E-mail: _____

IF YOU DO NOT NAME A HEALTH CARE AGENT, HEALTH CARE PROVIDERS WILL ASK YOUR FAMILY OR AN ADULT WHO KNOWS YOUR PREFERENCES AND VALU.ES FOR HELP IN DETERMINING YOUR WISHES FOR TREATMENT. NOTE THAT YOU MAY NOT APPOINT YOUR DOCTOR OR OTHER HEALTH CARE PROVIDER AS YOUR HEALTH CARE AGENT UNLESS RELATED TO YOU BY BLOOD, MARRIAGE OR ADOPTION.

If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the elate of this document, I appoint the person or persons named below in the order named. (It is helpful, but not required, to name alternative health care agents.)

First Alternative Health Care Agent: _____
(Name and relationship)

Address: _____

Telephone Number: Home_____Work_____

Email: _____

Second alternative health care agent: _____

(Name and relationship)

Address: _____

Telephone Number: Home_____Work_____

E-mail: _____

GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL) GOALS

If l have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your personal priorities such as comfort, care, preservation of mental function, etc.):

_____

_____

_____

In order to help understand what you want from medical treatment, place your initials in the box which reflects your values. Remember that these are used only to help inform your physician and guide your Health Care Agent in making health decisions if you are not able to communicate your wishes:

If I am in these situations:	I want to continue living like this	I'm not sure	I do not want to live like this
Cannot understand what I read or cannot carry on a conversation due to dementia or brain injury.			
Need to stay in a nursing home for the rest of my life.			
Need somebody to take care of me (bathing, feeding, using the bathroom, and getting dressed) for the rest of my life.			
Can't go outside on my own for the rest of my life.			

SEVERE BRAIN DAMAGE OR BRAIN DISEASE

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome. I therefore request that my health care agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below.

Initials I agree _____

Initials I disagree _____

PART III

HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF END-STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS

(LIVING WILL)

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make or communicate my treatment decisions:

IF I HAVE AN END-STAGE MEDICAL CONDITION (WHICH WILL RESULT IN MY DEATH, DESPITE THE INTRODUCTION OR CONTINUATION OF MEDICAL TREATMENT) OR AM PERMANENTLY UNCONSCIOUS SUCH AS AN IRREVERSIBLE COMA OR AN IRREVERSIBLE VEGETATIVE STATE AND THERE IS NO REALISTIC HOPE OF SIGNIFICANT RECOVERY, ALL OF THE FOLLOWING APPLY (CROSS OUT ANY TREATMENT INSTRUCTIONS WITH WHICH YOU DO NOT AGREE):

l. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming.

2. I direct that all life prolonging procedures be withheld or withdrawn. You may want to consult with your physician and attorney in order to determine whether your designated choices regarding end-of-life care are compatible with anatomical donation. In order to donate an organ your body may need to be maintained on artificial support after you have been declared dead to facilitate anatomical donation. Detailed information about the procedure for being declared brain dead or dead by lack of cardiac function and information about organ donation can be found on the Department of Transportation's publicly accessible Internet website.

3. I specifically do not want any of the following as life prolonging procedures: (If you wish to receive any of these treatments, write "I do want" after the treatment)

heart-lung resuscitation (CPR)_____
mechanical ventilator (breathing machine)_____
dialysis (kidney machine)_____
surgery_____
chemotherapy _____
radiation treatment _____
antibiotics _____

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries, or veins if you have an end-stage medical condition or are pem1anently unconscious and there is no realistic hope of significant recovery. (Initial only one statement.)

TUBE FEEDINGS
_____I want tube feedings to be given

NO TUBE FEEDINGS
_____I do not want tube feedings to be given.

4. If I have authorized donation of an organ (such as a heart, liver or lung) or a vascularized composite allograft in the next section of this document, authorize the use of artificial support, including a ventilator, for a limited period of time after I am declared dead to facilitate the donation.

5. I specifically do not want to be on artificial support after I am declared dead._____

HEALTH CARE AGENT'S USE OF INSTRUCTIONS (INITIAL ONE OPTION ONLY)

_____My health care agent must follow these instructions. OR

_____These instructions arc only guidance. My health care agent shall have final say and may override any of my instructions. (Indicate any exceptions)

_____

_____

If I did not appoint a health care agent, these instructions shall be followed.

LEGAL PROTECTION

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my heal.th care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions.

SIGNATURE _____

INFORMATION ABOUT ANATOMICAL DONATION

Donating an organ or other part of the body is a voluntary act. Under Pennsylvania law, you do not have to donate an organ or any other part of your body. It is important to know the effect of organ donation on your decisions about end-of-life care so that your wishes about end-of-life care will be fulfilled. If someone wishes to become an organ donor, the person may be kept on artificial support

after the person has been declared dead to facilitate anatomical donation. Detailed information about the procedure for recovering organs and other parts of the body and detailed information about brain death and cardiac death may be found on the Department of Transportation's publicly accessible Internet website.

Under Pennsylvania law, the organ donor designation on the Driver's license authorizes the individual to donate what we traditionally think of as organs (for example, heart, lung, liver, kidney) and tissue and does not authorize the individual to donate hands, facial tissue, limbs or other vascularized composite allografts.

Under Pennsylvania law, explicit and specific consent to donate hands, facial tissue, limbs and other vascularized composite allografts is needed. Donation of these parts of the body is voluntary. Information about the procedure to transplant hands, facial tissue and limbs can be found on the Department of Transportation's publicly accessible Internet website. It is important to know that donating a hand, limb or facial tissue may impact funeral arrangements and that an open casket may not be possible.

ORGAN DONATION

_____I consent to making an anatomical gift. This gift does not include hands, facial tissue, limbs or other vascularized composite allografts. I understand that if I want to donate a hand, facial tissue, limb or other vascularized composite allograft, there is another place in this document for me to do so. I also understand the hospital may provide artificial support, which may include a ventilator, after I am declared dead in order to facilitate donation. consent to making a gift of the fo11owing parts of my body for transplantation or research (please insert any limitations you desire on donation of specific organs or tissues or eyes or any limitation on the use of a donated part of the body): _____

SIGNATURE_____DATE_____

GIFT OF HANDS, FACIAL TISSUE, LIMBS AND OTHER VASCULARIZED COMPOSITE ALLOGRAFTS

_____I consent to making a gift of my hands, facial tissue, limbs or other vascularized composite allografts. I also understand that I have the option of requesting reconstruction of my body in preparation for burial and that anonymity of identity may not be able to be protected in the case of donation of hands, facial tissue or limbs. I also understand that burial arrangements may be affected and that an open casket may not be possible. I also understand that the hospital may provide artificial support, which may include a ventilator, after I am declared dead in order to facilitate donation.

Please insert any limitations you desire on donation of hands, facial tissue, limbs or other vascularized composite allografts and whether you request reconstructive surgery before burial:

_____

SIGNATURE_____DATE_____

_____I do not consent to donating my organs, tissues or any other part of my body, including hands, facial tissue, limbs or other vascularized composite allografts. This provision serves as a refusal to donate any part of my body. This provision also serves as a revocation of any prior decision I have made to donate organs, tissues or other parts of my body, including hands, facial tissue, limbs or other vascularized composite allograft: made in a prior document, including a driver's license, will, power of attorney, health care power of attorney or other document.

SIGNATURE_____DATE_____

Having carefully read this document, I have signed it this day of , 20_, revoking all previous health care powers of attorney and health care treatment instructions.

_____
(SIGN FULL NAME HERE FOR HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE TREATMENT INSTRUCTIONS)

WITNESS: _____

WITNESS: _____

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)

NOTARIZATION (OPTIONAL)

(Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other states.)

On this_____day of _____, 20_, before me personally appeared the aforesaid declarant and principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of _____, State of _____ the day and year first above written.

Notary Public _____

My commission expires _____