MyCareVoice.com
ADVANCE DIRECTIVE SOLUTIONS

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, John Jacob, am a resident of Delaware County, State of Utah, and if I am unable to make decisions regarding my own health care and my attending physician and another physician certify in writing that I am no longer able to make decisions regarding my health care, I nominate the following person(s) to serve as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. If my state has a different manner of determining whether I am unable to make decisions regarding my own health care, then my state's manner of making such a determination should be followed.

DESIGNATION OF PRIMARY AND ALTERNATE AGENT(S)

I hereby appoint the following as my true and lawful attorney-in-fact who are authorized to act for me as specified below:

Primary Agent:

Name: Jan Jacob

Relation to Me: Spouse

Address: 123 W Main St

City / State / Zip: Oologah, OK 74053

Home Phone: 918-000-1234

Cell Phone: 918-111-1234

Email: janj@mail.com

In the event I revoke my Primary Agent's authority or if my Primary Agent is not willing, able or reasonably available to make health care decision(s) on my behalf, I designate as my First Alternate Agent:

First Alternate Agent:

Name: _____

Relation to Me: _____

Address: _____

City / State / Zip: _____

Home Phone: _____

Cell Phone: _____

Email: _____

In the event I revoke my Primary Agent and First Alternate Agent's authority or if my Primary Agent and First Alternate Agent are not willing, able or reasonably available to make health care decision(s) on my behalf, I designate as my Second Alternate Agent:

Second Alternate Agent:

Name: _____

Relation to Me: _____

Address: _____

City / State / Zip: _____

Home Phone: _____

Cell Phone: _____

Email: _____

If I fail to designate an alternate agent, I am deliberately declining to designate an alternate agent.

The individuals I have designated as my Agent or Alternate Agent (s) are at least 18 years old (If I am a resident of Colorado my Agent or Alternate Agent(s) are at least 21 years old) and are **NOT** any of the following:

- My health care provider, an employee, agent, or relative of such health care provider, or an owner, operator of a medical care facility that is treating me (for example, a hospital, nursing home, residential or community care center);
- A person serving as a health care proxy or agent representing 10 or more people;
- A person appointed to make the determination of my capacity to make decisions;
- A person which is subject to a protective order for which I am protected;
- A person appointed to be my guardian or conservator;
- A person whose license as a fiduciary has been revoked or suspended;
- An administrator or employee of a government agency which is financially responsible for my care (unless the person is a blood relative);
- A person who I have disqualified from making health care decisions for me.

Nothing herein shall negate the provisions of my living will ("My Care Voice Directive") and my attorney-in-fact is prohibited from ordering or consenting to any medical treatment or medical care that is contrary my living will. The powers granted herein shall not be affected by my subsequent incapacity or by lapse of time.

POWERS GRANTED TO MY AGENT

My Agent knows and understands my goals and wishes based upon guidance I have provided. My Agent has full authority to make decisions for me about my health care according to my goals and wishes. If the choice I would make is unclear, then my agent will decide based on what he or she believes to be in my best interests. My Agent's authority to interpret my wishes is intended to be as broad as possible, and may include or exclude the following powers:

1. SHALL NOT agree to, refuse, or withdraw consent to any type of medical care, treatment, surgical procedures, tests, or medication. To the extent such a decision does not conflict with my wishes expressed in a living will I may have created, my Agent may make decisions about using mechanical or other procedures that affect any bodily function, such as artificial respiration, artificially supplied nutrition and hydration (that is, tube feeding), cardiopulmonary resuscitation (CPR), or other forms of medical support, even if deciding to stop or withhold treatment could or would result in my death;

2. SHALL have access to medical records and information to the same extent that I am entitled to, including the right to disclose health information to others;

3. SHALL authorize my admission to or discharge from any medical facility, including but not limited to, any hospital, nursing home, residential care, assisted-living, or similar facility or service (my Agent may authorize such admission or discharge even against medical advice if it is deemed to be in my best interest);

4. SHALL contract for any health care related service or facility for me, or apply for private or public health care benefits, with the understanding that my Agent is not personally financially responsible for those contracts;

5. SHALL employ or terminate any medical, social service, or other support personnel who is responsible for my care;

6. SHALL NOT agree to or refuse the use of any medication or procedure intended to relieve pain or discomfort, even though that use may lead to physical damage or dependence or hasten, but not intentionally cause, my death;

7. SHALL authorize my participation in medical research related to my medical condition;

8. SHALL make decisions regarding organ and tissue donations, autopsy, and the disposition of my remains as permitted by law, to the extent such a decision does not conflict with my wishes expressed in a living will I may have created;

9. SHALL take any other action necessary to do what I authorize here, including signing waivers or other documents, pursuing any dispute resolution process, or taking legal action in my name.

SPECIAL INSTRUCTIONS OR LIMITATIONS FOR MY AGENT

I would like to provide the following special instructions to my Agent:

_____

_____

_____

_____

I would like to place the following limitations on my Agent and his or her powers:

No limitations

_____

_____

_____

_____

MISCELLANEOUS PROVISIONS

10. This Power of Attorney shall terminate upon written revocation by me or by my legally appointed guardian, or by my death. If applicable, the Power of Attorney for Health Care ends on the following date: _____.

11. This Power of Attorney may be amended in writing personally by me (not by my attorney-in-fact). Notwithstanding my attorney-in-fact shall follow any subsequent instructions, oral or written, that I may give my attorney-in-fact while I am competent.

12. My Agent shall be entitled to reimbursement for all reasonable costs and expenses actually incurred and paid by him or her on my behalf under any provision of this document.

13. I request that no conservatorship or guardianship proceeding be instituted in the event of my disability, it being my intention that this Durable Power of Attorney for Health Care shall permit my Agent to act on my behalf.

14. In the event that it becomes necessary for any court to appoint a conservator or guardian then to the extent that I am permitted do so, I hereby nominate my then acting Agent to serve as such conservator or guardian.

15. I intend for this Power of Attorney for Health Care to be universal, valid, and honored in any jurisdiction where it may be presented.

16. I hereby ratify and confirm all actions which may be taken by my Agent.

17. I hereby authorize the use of a photocopy of this Durable Power of Attorney Health Care, in lieu of the original copy executed by me, for the purpose of effectuating the terms and provisions hereof.

18. I hereby revoke, annul, and cancel any and all powers of attorney for health care previously executed by me, if any, and the same shall be of no further force or effect.

Signed this 21 day of September, 2021

(Signature)

John Jacob

(Printed Name)

Residence:

Address: 4999 Breeze Dr Dakota City 40505

County of Delaware, State of Utah

Date of birth: 09/01/1995

My Care Voice is meant to help you voice your intentions regarding your medical care wishes. It is not meant to provide you legal or medical advice. My Care Voice cannot guarantee your wishes as expressed herein will be followed. All states have laws regulating the form and execution of advanced directives and those laws are subject to change. If you have a specific question, please speak with a medical or legal professional for advice.