

INSTRUCTIONS

MICHIGAN DESIGNATION OF PATIENT ADVOCATE FOR HEALTH CARE

**PRINT YOUR
NAME AND
ADDRESS**

I _____
(name)

(address)

am of sound mind, and I voluntarily make this designation.

**PRINT THE
NAME,
ADDRESS AND
PHONE
NUMBERS OF
YOUR PATIENT
ADVOCATE**

I designate _____
(name of patient advocate)

residing at _____
(address)

(home phone number) (work phone number)

as my patient advocate to make care, custody, or medical treatment decisions for me only when I become unable to participate in medical treatment decisions. The determination of when I am unable to participate in medical treatment decisions shall be made by my attending physician and another physician or licensed psychologist.

If the first individual is unable, unwilling, or unavailable to serve as my patient advocate, then I designate:

(name of successor agent)

residing at _____
(address)

(home phone number) (work phone number)

to serve as my patient advocate.

**PRINT THE
NAME,
ADDRESS AND
PHONE
NUMBERS OF
YOUR
ALTERNATE
PATIENT
ADVOCATE**

I authorize my patient advocate to decide to withhold or withdraw medical treatment which could or would allow me to die. I am fully aware that such a decision could or would lead to my death.

In making decisions for me, my patient advocate shall be guided by my wishes, whether expressed orally, in a living will, or in this designation. If my wishes as to a particular situation have not been expressed, my patient advocate shall be guided by his or her best judgment of my probable decision, given the benefits, burdens and consequences of the decision, even if my death, or the chance of my death, is one consequence.

My patient advocate shall have the same authority to make care, custody and medical treatment decisions as I would if I had the capacity to make them EXCEPT *(here list the limitations, if any, you wish to place on your patient advocate's authority)*.

**LIST
LIMITATIONS TO
YOUR PATIENT
ADVOCATE'S
AUTHORITY
(IF ANY)**

This designation of patient advocate shall not be affected by my disability or incapacity. This designation of patient advocate is governed by Michigan law, although I request that it be honored in any state in which I may be found. I reserve the power to revoke this designation at any time by communicating my intent to revoke it in any manner in which I am able to communicate.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I voluntarily sign this designation of patient advocate after careful consideration. I accept its meaning and I accept its consequences.

**SIGN AND DATE
YOUR
DOCUMENT AND
PRINT YOUR
ADDRESS**

(your signature)

(date)

(your street address)

(city, Michigan, zip code)

**WITNESSING
PROCEDURE****WITNESSES
MUST SIGN AND
PRINT THEIR
NAME AND
ADDRESS****ACCEPTANCE
STATEMENT****Statement of Witnesses**

We sign below as witnesses. This designation was signed in our presence. The designator appears to be of sound mind, and to be making this designation voluntarily, and under no duress, fraud, or undue influence.

Witness 1: _____
(signature)

(print or type full name)

(address)

Witness 2: _____
(signature)

(print or type full name)

(address)

Acceptance by Patient Advocate and Successor Advocate (If Any)

(A) This designation shall not become effective unless the patient is unable to participate in treatment decisions.

(B) A patient advocate shall not exercise powers concerning the patient's care, custody and medical treatment that the patient, if the patient were able to participate in the decision, could not have exercised on his or her own behalf.

(C) This designation cannot be used to make a medical treatment decision to withhold or withdraw treatment from a patient who is pregnant that would result in the patient's death.

(D) A patient advocate may make a decision to withhold or withdraw treatment which would allow a patient to die only if the patient has expressed in a clear and convincing manner that the patient advocate is authorized to make such a decision, and that the patient acknowledges that such a decision could or would allow the patient's death.

(E) A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in performance of his or her authority, rights, and responsibilities.

(F) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests. The known desires of the patient expressed or evidenced while the patient is able to participate in medical treatment decisions are presumed to be in the patient's best interests.

(G) A patient may revoke his or her designation at any time and in any manner sufficient to communicate an intent to revoke.

(H) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

(I) A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, being section 333.20201 of the Michigan Compiled Laws.

(J) A patient advocate may choose to have the patient placed under hospice care.

**YOUR PATIENT
ADVOCATE
MUST SIGN
AND DATE
YOUR
DOCUMENT
HERE**

I understand the above conditions and I accept the designation as patient advocate for _____.
(name of principal)

Dated _____ Signed _____

**YOUR
ALTERNATE
PATIENT
ADVOCATE
MUST SIGN AND
DATE YOUR
DOCUMENT
HERE**

I understand the above conditions and I accept the designation of successor patient advocate for _____.
(name of principal)

Dated _____ Signed _____

INSTRUCTIONS

PARTNERSHIP FOR CARING LIVING WILL

PRINT YOUR
NAME

I, _____,
being of sound mind, make this statement as a directive to be followed if
I become permanently unable to participate in decisions regarding my
medical care. These instructions reflect my firm and settled commitment
to decline medical treatment under the circumstances indicated below:

I direct my attending physician to withhold or withdraw treatment that
merely prolongs my dying, if I should be in an **incurable or irreversible
mental or physical condition with no reasonable expectation of
recovery**, including but not limited to: (a) **a terminal condition**; (b) **a
permanently unconscious condition**; or (c) **a minimally conscious
condition in which I am permanently unable to make decisions or
express my wishes**.

I direct that treatment be limited to measures to keep me comfortable and
to relieve pain, including any pain that might occur by withholding or
withdrawing treatment.

While I understand that I am not legally required to be specific about
future treatments, **if I am in the condition(s) described above I feel
especially strongly about the following forms of treatment:**

I do not want cardiac resuscitation.
I do not want mechanical respiration.
I do not want tube feeding.
I do not want antibiotics.

However, I **do want** maximum pain relief, even if it may hasten my death.

CROSS OUT
ANY
STATEMENTS
THAT DO NOT
REFLECT YOUR
WISHES

**ADD PERSONAL
INSTRUCTIONS
(IF ANY)**

Other directions (insert personal instructions):

These directions express my legal right to refuse treatment under federal and state law. I intend my instructions to be carried out, unless I have revoked them in a new writing or by clearly indicating that I have changed my mind.

**SIGN AND DATE
THE DOCUMENT
AND PRINT
YOUR ADDRESS**

Signed: _____ Date: _____

Address: _____

**WITNESSING
PROCEDURE**

I declare that the person who signed this document appeared to execute the living will willingly and free from duress. He or she signed (or asked another to sign for him or her) this document in my presence.

**Two
WITNESSES
MUST SIGN AND
PRINT THEIR
ADDRESSES**

Witness: _____

Address: _____

Witness: _____

Address: _____
