Declaration for Mental Health Treatment

I_____, born on_____, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by two physicians or the court that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means electroconvulsive treatment, treatment of mental illness with psychotropic medication, and admission to and retention in a health care facility for a period up to 17 days.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

_____

_____

PSYCHOTROPIC MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

_____ I consent to the administration of the following medications:

_____

_____ I do not consent to the administration of the following medications:

_____

Conditions or limitations: _____

_____

_____

ELECTROCONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

_____ I consent to the administration of electroconvulsive treatment. _____ I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations:_____

_____

_____

_____

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding admission to and retention in a health care facility for mental health treatment are as follows:

_____ I consent to being admitted to a health care facility for mental health treatment.

_____ I do not consent to being admitted to a health care facility for mental health treatment.

This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.

Conditions or limitations:_____

_____

_____

SELECTION OF PHYSICIAN *(optional)*

If it becomes necessary to determine if I have become incapable of giving or withholding informed consent for mental health treatment, I choose Dr. _____ of _____ to be one of the two physicians who will determine whether I am incapable. If that physician is unavailable, that physician's designee shall determine whether I am incapable.

ADDITIONAL REFERENCES OR INSTRUCTIONS

_____

_____

_____

Conditions or limitations: _____

_____

ATTORNEY-IN-FACT

I hereby appoint:

NAME_____

ADDRESS _____

TELEPHONE# _____

to act as my attorney-in-fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

(continued)

ATTORNEY-IN-FACT *(continued)*

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my attorney-in-fact, I authorize the following person to act as my attorney-in-fact:

NAME_____

ADDRESS_____

TELEPHONE# _____

My attorney-in-fact is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my attorney-in-fact. If my wishes are not expressed and are not otherwise known by my attorney-in-fact, my attorney-in-fact is to act in what he or she believes to be my best interest.

_____

(Signature of Principal/Date)

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this declaration for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is:

A person appointed as an attorney-in-fact by this document;

The principal's attending physician or mental health service provider or a relative of the physician or provider;

The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or

A person related to the principal by blood, marriage or adoption.

Witnessed By:

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as attorney-in-fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental health treatment only while the principal is incapable as determined by a court or two physicians. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner when the principal is not incapable.

_____ _____

(Signature of Attorney-in-fact/Date) (Printed Name of Witness)

_____ _____

(Signature of Attorney-in-fact/Date) (Printed Name of Witness)

(continued)

NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about three types of mental health treatment: psychotropic medication, electroconvulsive therapy, and short-term (up to 17 days) admission to a treatment facility. The instructions that you include in this declaration will be followed only if two physicians or the court believes that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

You may also appoint a person as your attorney-in-fact to make these treatment decisions for you if you become incapable. The person you appoint has a duty to act consistent with your desires as stated in this document or, if your desires are not stated or otherwise made known to the attorney-in-fact, to act in a manner consistent with what the person in good faith believes to be in your best interest. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your attorney-in-fact at any time.

This document will continue in effect for a period of three years unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

You have the right to revoke this document in whole or in part at any time you have been determined by a physician to be capable of giving or withholding informed consent for mental health treatment. A revocation is effective when it is communicated to your attending physician in writing and is signed by you and a physician. The revocation may be in a form similar to the following:

REVOCATION

I,_____, willfully and voluntarily revoke my declaration for mental health treatment as indicated

☐ I revoke my entire declaration

☐ I revoke the following portion of my declaration

_____

_____

_____

Date _____ Signed _____
(Signature of principal)

I, Dr. _____, have evaluated the principal and determined that he or she is capable of giving or withholding informed consent for mental health treatment.

Date _____ Signed _____
(Signature of physician)

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

History
(Source: P.A. 89-439, § 75.) - Form Made Fillable by eForms

Living Will

DECLARATION

This declaration is made this _____ day of_____ (month, year).

I, _____, born on _____, being of sound mind, willfully and voluntarily make known my desires that my moment of death shall not be artificially postponed.

If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such death delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Signed_____

City, County and State of Residence_____

The declarant is personally known to me and I believe him or her to be of sound mind. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he or she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant's signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.

Witness _____

Witness _____

History
(Source: P.A. 85-1209.)
Annotations

State of Illinois
Illinois Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)	Gender ❑ M ❑ F	
Address (street/city/state/ZIPcode)		

A — CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

Check One

❑ **Attempt Resuscitation/CPR** ❑ **Do Not Attempt Resuscitation/DNR**

(*Selecting CPR means* **Full Treatment** *in Section B is selected*)

When not in cardiopulmonary arrest, follow orders B and C.

B — MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.

Check One *(optional)*

❑ **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*

❑ **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*

❑ **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Optional Additional Orders _____

C — MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired.

Check One *(optional)*

❑ Long-term medically administered nutrition, including feeding tubes.

❑ Trial period of medically administered nutrition, including feeding tubes.

❑ No medically administered means of nutrition, including feeding tubes.

Additional Instructions (e.g., length of trial period)

_____

_____

D — DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

❑ Patient ❑ Agent under health care power of attorney

❑ Parent of minor ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature ***(required)***	Name (print)	Date
_____	_____	_____

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature ***(required)***	Name (print)	Date
_____	_____	_____

E — Signature of Authorized Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Authorized Practitioner Name ***(required)***	Phone ( ) _____ - _____
_____	
Authorized Practitioner Signature ***(required)***	Date ***(required)***
_____	_____

Form Revision Date - May 2017 **(Prior form versions are also valid.)**

THIS SIDE FOR INFORMATIONAL PURPOSES ONLY		
Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

❑ Health Care Power of Attorney	❑ Living Will Declaration	❑ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- **The completion of a POLST form is always voluntary, cannot be mandated and may be changed at any time.**
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g. ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at
http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

State of Illinois
Illinois Department of Public Health

Illinois Statutory Short Form
Power of Attorney for Health Care

NOTICE TO THE INDIVIDUAL SIGNING THE POWER OF ATTORNEY FOR HEALTH CARE

No one can predict when a serious illness or accident might occur. When it does, you may need someone else to speak or make health care decisions for you. If you plan now, you can increase the chances that the medical treatment you get will be the treatment you want.

In Illinois, you can choose someone to be your "health care agent." Your agent is the person you trust to make health care decisions for you if you are unable or do not want to make them yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of agent in writing. The written form is often called an "advance directive". You may use this form or another form, as long as it meets the legal requirements of Illinois. There are many written and on-line resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing your advance directive.

WHAT ARE THE THINGS I WANT MY HEALTH CARE AGENT TO KNOW?

The selection of your agent should be considered carefully, as your agent will have the ultimate decision-making authority once this document goes into effect, in most instances after you are no longer able to make your own decisions. While the goal is for your agent to make decisions in keeping with your preferences and in the majority of circumstances that is what happens, please know that the law does allow your agent to make decisions to direct or refuse health care interventions or withdraw treatment. Your agent will need to think about conversations you have had, your personality, and how you handled important health care issues in the past. Therefore, it is important to talk with your agent and your family about such things as:

(i) What is most important to you in your life?

(ii) How important is it to you to avoid pain and suffering?

(iii) If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?

(iv) Would you rather be at home or in a hospital for the last days or weeks of your life?

(v) Do you have religious, spiritual, or cultural beliefs that you want your agent and others to consider?

(vi) Do you wish to make a significant contribution to medical science after your death through organ or whole body donation?

(vii) Do you have an existing advance directive, such as a living will, that contains your specific wishes about health care that is only delaying your death? If you have another advance directive, make sure to discuss with your agent the directive and the treatment decisions contained within that outline your preferences. Make sure that your agent agrees to honor the wishes expressed in your advance directive.

WHAT KIND OF DECISIONS CAN MY AGENT MAKE?

If there is ever a period of time when your physician determines that you cannot make your own health care decisions, or if you do not want to make your own decisions, some of the decisions your agent could make are to:

(i) talk with physicians and other health care providers about your condition.

(ii) see medical records and approve who else can see them.

(iii) give permission for medical tests, medicines, surgery, or other treatments.

(iv) choose where you receive care and which physicians and others provide it.

(v) decide to accept, withdraw, or decline treatments designed to keep you alive if you are near death or not likely to recover. You may choose to include guidelines and/or restrictions to your agent's authority.

(vi) agree or decline to donate your organs or your whole body if you have not already made this decision yourself. This could include donation for transplant, research, and/or education. You should let your agent know whether you are registered as a donor in the First Person Consent registry maintained by the Illinois Secretary of State or whether you have agreed to donate your whole body for medical research and/or education.

(vii) decide what to do with your remains after you have died, if you have not already made plans.

(viii) talk with your other loved ones to help come to a decision (but your designated agent will have the final say over your other loved ones).

Your agent is not automatically responsible for your health care expenses.

WHOM SHOULD I CHOOSE TO BE MY HEALTH CARE AGENT?

You can pick a family member, but you do not have to. Your agent will have the responsibility to make medical treatment decisions, even if other people close to you might urge a different decision. The selection of your agent should be done carefully, as he or she will have ultimate decision-making authority for your treatment decisions once you are no longer able to voice your preferences. Choose a family member, friend, or other person who:

(i) is at least 18 years old;

(ii) knows you well;

(iii) you trust to do what is best for you and is willing to carry out your wishes, even if he or she may not agree with your wishes;

(iv) would be comfortable talking with and questioning your physicians and other health care providers;

(v) would not be too upset to carry out your wishes if you became very sick; and

(vi) can be there for you when you need it and is willing to accept this important role.

WHAT IF MY AGENT IS NOT AVAILABLE OR IS UNWILLING TO MAKE DECISIONS FOR ME?

If the person who is your first choice is unable to carry out this role, then the second agent you chose will make the decisions; if your second agent is not available, then the third agent you chose will make the decisions. The second and third agents are called your successor agents and they function as back-up agents to your first choice agent and may act only one at a time and in the order you list them.

WHAT WILL HAPPEN IF I DO NOT CHOOSE A HEALTH CARE AGENT?

If you become unable to make your own health care decisions and have not named an agent in writing, your physician and other health care providers will ask a family member, friend, or guardian to make decisions for you. In Illinois, a law directs which of these individuals will be consulted. In that law, each of these individuals is called a "surrogate".

There are reasons why you may want to name an agent rather than rely on a surrogate:

(i) The person or people listed by this law may not be who you would want to make decisions for you.

(ii) Some family members or friends might not be able or willing to make decisions as you would want them to.

(iii) Family members and friends may disagree with one another about the best decisions.

(iv) Under some circumstances, a surrogate may not be able to make the same kinds of decisions that an agent can make.

WHAT IF THERE IS NO ONE AVAILABLE WHOM I TRUST TO BE MY AGENT?

In this situation, it is especially important to talk to your physician and other health care providers and create written guidance about what you want or do not want, in case you are ever critically ill and cannot express your own wishes. You can complete a living will. You can also write your wishes down and/or discuss them with your physician or other health care provider and ask him or her to write it down in your chart. You might also want to use written or on-line resources to guide you through this process.

WHAT DO I DO WITH THIS FORM ONCE I COMPLETE IT?

Follow these instructions after you have completed the form:

(i) Sign the form in front of a witness. See the form for a list of who can and cannot witness it.

(ii) Ask the witness to sign it, too.

(iii) There is no need to have the form notarized.

(iv) Give a copy to your agent and to each of your successor agents.

(v) Give another copy to your physician.

(vi) Take a copy with you when you go to the hospital.

(vii) Show it to your family and friends and others who care for you.

WHAT IF I CHANGE MY MIND?

You may change your mind at any time. If you do, tell someone who is at least 18 years old that you have changed your mind, and/or destroy your document and any copies. If you wish, fill out a new form and make sure everyone you gave the old form to has a copy of the new one, including, but not limited to, your agents and your physicians.

WHAT IF I DO NOT WANT TO USE THIS FORM?

In the event you do not want to use the Illinois statutory form provided here, any document you complete must be executed by you, designate an agent who is over 18 years of age and not prohibited from serving as your agent, and state the agent's powers, but it need not be witnessed or conform in any other respect to the statutory health care power.

If you have questions about the use of any form, you may want to consult your physician, other health care provider, and/or an attorney.

State of Illinois
Illinois Department of Public Health

Illinois Statutory Short Form
Power of Attorney for Health Care

MY POWER OF ATTORNEY FOR HEALTH CARE

THIS POWER OF ATTORNEY REVOKES ALL PREVIOUS POWERS OF ATTORNEY FOR HEALTH CARE

My name (Print your full name): _____

My address: _____

I WANT THE FOLLOWING PERSON TO BE MY HEALTH CARE AGENT (an agent is your personal representative under state and federal law):

(Agent name) _____

(Agent address) _____

(Agent phone number) _____

Please check box if applicable:

☐ If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as guardian.

MY AGENT CAN MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING:

(i) Deciding to accept, withdraw, or decline treatment for any physical or mental condition of mine, including life-and-death decisions.

(ii) Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.

(iii) Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.

(iv) Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue, or whole body donation, autopsy, cremation, and burial.

I AUTHORIZE MY AGENT TO: (Please check only one box. If no box is checked, or if more than one box is checked, the directive in the first box below shall be implemented.)

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. Starting now, for the purpose of assisting me with my health care plans and decisions, my agent shall have complete access to my medical and mental health records, the authority to share them with others as needed, and the complete ability to communicate with my personal physician(s) and other health care providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself.

☐ Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

LIFE-SUSTAINING TREATMENTS:

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes. Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements. SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES **(optional)**:

☐ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.

☐ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically on the lines below or add another page if needed:

_____

_____

_____

_____

YOU MUST SIGN THIS FORM AND A WITNESS MUST ALSO SIGN IT BEFORE IT IS VALID.

My signature: _____ Today's date: _____

HAVE YOUR WITNESS AGREE TO WHAT IS WRITTEN BELOW, AND THEN COMPLETE THE SIGNATURE PORTION:

I am at least 18 years old. (Check one of the options below.)

☐ I saw the principal sign this document, or

☐ the principal told me that the signature or mark on the principal signature line is his or hers.

I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent, or the successor agent(s) by blood, marriage, or adoption. I am not the principal's physician, advanced practice registered nurse, dentist, podiatric physician, optometrist, psychologist, or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the health care facility where the principal is a patient or resident.

Witness printed name: _____

Witness address: _____

Witness signature: _____ Today's date: _____

SUCCESSOR HEALTH CARE AGENT(S) (optional):

If the agent I selected is unable or does not want to make health care decisions for me, then I request the person(s) I name below to be my successor health care agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names).

_____

(Successor agent #1 name, address and phone number)

_____

(Successor agent #2 name, address and phone number)