Durable Power Of Attorney For Health Care
Appointment of Patient Advocate

(Please print or type)

I. Appointment of Patient Advocate

I, ____
(your full name)

of ____
(your complete legal address)

appoint ____
(name of person you want to be your advocate)

who lives at ____
(that person's complete legal address)

as my patient advocate. My patient advocate can make decisions about my medical care. If I am disabled or incapacitated, this Durable Power of Attorney is still in effect. This Durable Power of Attorney is governed by Sections 700.5506 through 700.5512 of the Michigan Compiled Laws.

If the person named cannot serve as advocate, I then appoint:

name ____
(name of second person you want to be your advocate)

who lives at ____
(that person's complete address)

to serve as my patient advocate.

This Durable Power of Attorney starts when two doctors put in writing that I cannot make medical decisions for myself.

If my religion will not let me be seen by a doctor, then my wishes are as follows:

____

____

____
(use attached sheet if you need to)

A copy of this form will be put in my medical record. I can change this Durable Power of Attorney at any time.

II. Grants of Authority and Responsibility

My advocate can:

- ☐ Get access to my medical records
- ☐ Hire and fire doctors.
- ☐ Give informed consent: Find out what my health problems are, how to treat them, and ask any questions.
- ☐ Refuse or stop any medical treatment
- ☐ MAKE DECISIONS THAT COULD ALLOW MY DEATH. Use Section III to make your wishes clear.
- ☐ Approve care that I may need or stop care that I am getting.

III. Desires and Preferences for Treatment (optional)

My Patient Advocate is to make medical decisions for me based on what I have told him or her about my wishes for medical care. I want my Patient Advocate to consider the burdens and benefits of treatment. My Patient Advocate should decide if pain relief or my quality of life is more important than keeping me alive longer.

Definition of Life Support: Life support can mean any treatment to keep me alive. For example: CPR, food and water supplied by tube feeding and/or IV's, medicine, surgery, blood transfusions, dialysis, breathing machines, etc.

Choice #1:

If I am close to death and life support treatment would only delay my death, then *(choose one)*

☐ I do want life support treatment.

☐ I do not want life support treatment. It must be stopped if it's been started. I know this decision could or would allow me to die.

Choice #2:

I am in a coma.
My doctor says that I will remain unconscious for the rest of my life.

☐ I do want life support treatment.

☐ I do not want life support treatment. It must be stopped if it's been started. I know this decision could or would allow me to die.

Choice #3:

I am in a vegetative state: I have permanent and severe brain damage and I am not expected to recover.

☐ I do want life support treatment.

☐ I do not want life support treatment. It must be stopped if it's been started. I know this decision could or would allow me to die.

Choice #4:

I want to be kept alive. No matter my condition or chances for recovery, I want every possible treatment. No matter the cost of my care, I want life support treatment given to keep me alive.

Additional wishes for my treatment including specific cultural and religious practices, are as follows:

____

____

____

IV. Signature of Principal

I sign this of my own free will. I sign in the presence of these witnesses.

____________________________ ____________

(Your signature) *(Date)*

____

(Print or type full name)

____

(Address)

____

City *State* *Zip*

ATTESTATION OF WITNESSES

I am witnessing the Durable Power of Attorney. The person signing this document seems to be of sound mind. The person signing this document seems to be under no duress or influence. I am not that person's relative or doctor. I am not the named advocate. I am not an employee of the insurance company. I am not an employee of the hospital or nursing home.

____________________ ____________________

(First Witness' Signature) *(Address)*

____

(Type or print name) *(City)* *(State/Zip)*

____________________ ____________________

(Second Witness' Signature) *(Address)*

____

(Type or print name) *(City)* *(State/Zip)*

V. Acceptance to the Designation of Power of Attorney

I, ____ accept the responsibility
(Print patient advocate's name-1)

given to me by ____________________________________ to be the patient advocate
(Print principal's name-1)

in the durable power of attorney documented signed on ___________________.
(Date)

I, ____ accept the responsibility
(Print patient advocate's name-2)

given to me by ____________________________________ to be the patient advocate
(Print principal's name-2)

in the durable power of attorney documented signed on ___________________.
(Date)

I can change my mind about this at any time. By signing below, I agree that I have read and understood what I need to do. The requirements of Michigan law are:

(A) I become advocate only when the patient cannot make medical decisions.
(B) I can only do for the patient what the patient could have done himself.
(C) I cannot change or stop treatment if the patient is pregnant and that would result in the pregnant patient's death.
(D) The patient must state clearly if the advocate can make decisions that might cause the patient's death.
(E) I do not receive any money for doing this.
(F) I will act in the patient's best interests. (I'm willing to follow the patient's wishes.)
(G) The patient may change this designation at any time.
(H) The patient advocate may change his mind about accepting at any time.
(I) A patient in the hospital has the following rights:

A patient in a hospital or nursing home may not be denied care on the basis of race, religion, color, national origin, sex, age, disability, martial status, sexual preference, or source of payment.

Patients are entitled to:

- See their medical record. Know that their medical record is kept confidential.
- Receive appropriate care. Receive information about their medical condition.
- Refuse treatment and be informed about what might happen. The hospital may end the relationship with the patient on reasonable notice.
- Information about the hospital's policy for patient complaints.
- Receive and see an explanation of the bill. This is no matter what type of payment is arranged.
- Be able to talk to his or her physician. Be able to send and receive personal mail unopened on the same day. This is unless the doctor has a documented medical reason why not.

1.____ ______________________
(Advocate's Signature) *(Date)*

2.____ ______________________
(Advocate's Signature) *(Date)*