Power of Attorney for Health Care

(Wisconsin Statutes §§ 155.01 to 155.80)

NOTICE TO PERSON MAKING THIS DOCUMENT

YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.

BECAUSE YOUR HEALTH-CARE PROVIDERS IN SOME CASES MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.

IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH-CARE DECISIONS FOR YOU IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH-CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH-CARE AGENT. IF YOUR HEALTH-CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH-CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISION.

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH-CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY SIGNING A WRITTEN AND DATED STATEMENT, OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH-CARE PROVIDERS, AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.

YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR RECORD OF GIFT THAT YOU MAY HAVE MADE. YOU MAY REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE BY THIS DOCUMENT BY CROSSING OUT THE ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.

IT IS SUGGESTED THAT YOU KEEP THE ORIGINAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.

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1. I, _____ (print or type full name), fill out this document to set forth my treatment instructions and to appoint a health-care agent in case of my incapacity.

2. I am one of Jehovah's Witnesses, and I direct that **NO TRANSFUSIONS of whole blood, red cells, white cells, platelets, or plasma** be given me under any circumstances, even if health-care providers believe that such are necessary to preserve my life. (Acts 15:28, 29) I refuse to predonate and store my blood for later infusion.

3. **Regarding end-of-life matters:** [initial <u>one</u> of the two choices]

   (a) _____ I do not want my life to be prolonged if, to a reasonable degree of medical certainty, my situation is hopeless.

   (b) _____ I want my life to be prolonged as long as possible within the limits of generally accepted medical standards, even if this means that I might be kept alive on machines for years.

4. **Regarding other health-care instructions** (such as current medications, allergies, medical problems, or any other comments about my health-care wishes), I direct that:

   _____

   _____

   _____

   _____

   _____

   _____

   _____

5. I give no one (including my agent) any authority to disregard or override my instructions set forth herein. Family members, relatives, or friends may disagree with me, but any such disagreement does not diminish the strength or substance of my refusal of blood or other instructions.

6. Apart from the matters covered above, I appoint the person named herein as my agent to make health-care decisions for me. I give my agent full power and authority to consent to or to refuse treatment (including artificial nutrition and hydration) on my behalf, to consult with my doctors and receive copies of my medical records, and to take legal action to ensure that my wishes are honored. If my first appointed agent is unavailable, unable, or unwilling to serve, I appoint an alternate agent herein to serve with the same power and authority.

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7. **Regarding admission to nursing homes or community-based residential facilities:** I authorize my health-care agent to admit me, if necessary, to a nursing home or community-based residential facility for short-term and long-term stays for both recuperative or respite care and non-recuperative or non-respite care.

   [initial here, if you agree] _____

8. **Regarding the provision of feeding tubes:** I authorize my health-care agent to make decisions on my behalf about the providing, withholding, or withdrawing of feeding tubes.

   [initial here, if you agree] _____

9. **Regarding health-care decisions for pregnant women [if applicable]:** I direct that my health-care provider and my health-care agent fully honor my refusal of blood transfusions even if I am pregnant. In the event of my incapacity, my health-care agent has the authority to make health-care decisions for me even while I am pregnant.

   [initial here, if applicable] _____

10. THIS POWER OF ATTORNEY FOR HEALTH CARE MUST BE SIGNED AND DATED BY THE PRINCIPAL, BY TWO WITNESSES, AND BY THE HEALTH-CARE AGENT AND ALTERNATE HEALTH-CARE AGENT.

SIGNATURE OF PRINCIPAL

_____ _____
(Signature*) (Date)

_____
(Address)

STATEMENT OF WITNESSES

I know the principal (the person who signed this document above) personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this Power of Attorney for Health Care is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, or adoption, and am not directly financially responsible for the principal's health care. I am not a health-care provider who is serving the principal at this time, an employee of the health-care provider, other than a chaplain or a social worker, or an employee, other than a chaplain or a social worker, of an inpatient health-care facility in which the principal is a patient. **I am not the principal's health-care agent or alternate agent.** To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

_____ _____
(Signature of witness / Date) (Signature of witness / Date)

_____ _____
(Address) (Address)

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STATEMENT OF HEALTH-CARE AGENT AND ALTERNATE HEALTH-CARE AGENT

I understand that _____ (*name of principal*) has designated me to be his or her health-care agent or alternate health-care agent if he or she is ever found to have incapacity and unable to make health-care decisions himself or herself.

Also, _____ (*name of principal*) has discussed his or her desires regarding health-care decisions with me.

_____
(Signature of health-care agent)

_____
(Print name)

_____
(Address)

_____
(Signature of alternate health-care agent)

_____
(Print name)

_____
(Address)

HEALTH-CARE AGENT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

ALTERNATE HEALTH-CARE AGENT*

Name: _____

Address: _____

_____

Telephone(s): _____

_____

*** Note:** Before signing this document, fill out the entire document (including the names, addresses, and telephone numbers of your health-care agents). You should sign this document in the presence of two witnesses and have your health-care agents sign the above statement. You may appoint any adult to be your agent except (1) your nonrelative health-care provider, (2) the nonrelative employee of your health-care provider, (3) the nonrelative employee of a health-care facility in which you are a patient or reside, or (4) the nonrelative spouse of any of the above-mentioned persons. A "nonrelative" is a person who is not related to you by blood, marriage, or adoption.

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(signed document inside)

NO BLOOD