INSTRUCTIONS

PRINT YOUR NAME

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR AGENT

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR ALTERNATE AGENT

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Part One: Durable Power of Attorney for Health Care Decisions

GRANT OF AUTHORITY TO AGENT

I , ____,
(name)

designate and appoint: ______________________________________
(name of agent)

____
(address)

____
(home telephone number) (work telephone number)

or, in the event the person I appoint above is unable, unwilling or unavailable to serve, I appoint:

____
(name of alternate agent)

____
(address)

____
(home telephone number) (work telephone number)

to be my agent for health care decisions and pursuant to the language stated below, on my behalf to:

(1) Consent, refuse consent, or withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition, and to make decisions about organ donation, autopsy, and disposition of the body;

(2) make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge health care personnel, to include physicians, psychiatrists, psychologists, dentists, nurses, therapists, or any other person who is licensed, certified, or otherwise authorized or permitted by the laws of this state to administer health care, as the agent shall deem necessary for my physical, mental, and emotional well being; and

(3) request, receive, and review any information, verbal or written, regarding my personal affairs or physical or mental health, including medical and hospital records, and to execute any releases of other documents that may be required in order to obtain such information.

In exercising the grant of authority set forth above my agent for health care decisions shall: (Here may be inserted any special instructions or statement of the principal's desires to be followed by the agent in exercising the authority granted)

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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(attach additional pages if needed)

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LIST LIMITATIONS ON YOUR AGENT'S POWER TO CONSENT TO MEDICAL TREATMENT (IF ANY)

LIST FURTHER LIMITATIONS TO YOUR AGENT'S POWER (IF ANY)

LIMITATIONS OF AUTHORITY

(1) The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney for health care decisions, and by my wishes setout in Part Two (if I have filled out Part Two), and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the Natural Death Act.

(2) The agent shall be prohibited from authorizing consent for the following items:

____

____

____

____

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____

(3) This durable power of attorney for health care decisions shall be subject to the additional following limitations:

____

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EFFECTIVE TIME

This power of attorney for health care decisions shall become effective upon my disability or incapacity.

REVOCATION

Any durable power of attorney for health care decisions I have previously made is hereby revoked.

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INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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Part Two: Declaration

Declaration made this ___________ day of _______________, ______________
(day) (month) (year)

I, ____,
(name)

being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized, and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

I further direct that:

____

____

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____

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my agent (if any), family, and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

SIGN AND DATE THE DOCUMENT AND PRINT YOUR PLACE OF RESIDENCE

Part Three: Execution.

I understand the full importance of this document and I am emotionally and mentally competent to appoint an agent and/or make this declaration.

Signed ___________________________________ Date _____________________

City, County and State of Residence ____________________________________

____

YOUR SIGNATURE MUST BE EITHER WITNESSED OR NOTARIZED

Alternative No. 1, Witnesses:
The declarant has been personally known to me and I believe him or her to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not appointed above as the declarant's agent. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for the declarant's medical care.

WITNESS #1

Witness ____
Address ____

WITNESS #2

Witness ____
Address ____

OR

OR
Alternative No. 2, Acknowledged by a Notary Public:

A NOTARY PUBLIC MUST COMPLETE THIS SECTION OF YOUR DOCUMENT

STATE OF KANSAS)
) ss
County of__________________________)

This instrument was acknowledged before me on _____________________
(date)

by ____.
(name of principal)

____
(signature of notary public)

(Seal, if any)

My appointment expires: ________________
Copies: ___________

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Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

ORGAN DONATION (OPTIONAL)

KANSAS ORGAN DONATION FORM — PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your agent, guardian, or your family may have the authority to make a gift of all or part of your body under Kansas law.

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

_____ I do not want to make an organ or tissue donation and I do not want my agent, guardian, or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

ADD NAME OR INSTITUTION (IF ANY)

Name of individual/institution:______________________

_____ Pursuant to Kansas law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

For (initial one):
_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

Declarant name: ____

Declarant signature: ___________________________, Date: _____________

The declarant voluntarily signed or directed another person to sign this writing in my presence.

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness _________________________________Date__________________

Address ____

____

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness __________________________________Date_________________

Address ____

____

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Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your Advance Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Kansas document.

7. Be aware that your Kansas document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**