DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Statutory Advance Directives

For

Wisconsin Residents

Standard State Statutory
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For

Wisconsin Residents

Standard State Statutory
Advance Directive for
Health Care Choices

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive
for Wisconsin Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The Wisconsin state legislature has designed a living will as well as a power of attorney for health care for use by the public. As these documents were designed by the state legislature, each should be in full compliance with all applicable statutes and laws.

This directive consists of two parts. The first is the "Declaration to Physicians," which is the Wisconsin living will, where you can record your health care and treatment wishes. The second is the "Power of Attorney for Health Care" in which you can name someone to make health care and treatment decisions for you if you are ever unable to make or communicate them for yourself. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

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1. **Declaration Introduction**

The Declaration to Physicians (living will) form makes it possible for adults in Wisconsin to state their preferences for life-sustaining procedures and feeding tubes in the event the person is in a terminal condition or persistent vegetative state. The withholding or withdrawal of any medication, life-sustaining procedure or feeding tube may not be made if the attending physician advises that doing so will cause pain or reduce comfort and the pain or discomfort cannot be alleviated through pain relief measures.

Two witnesses are required. Witnesses must be at least 18 years of age, not related to you by blood, marriage or adoption, and not directly financially responsible for your health care. Witnesses also may not be persons who know they are entitled to or have claim on any portion of your estate. A witness cannot be a health care provider who is serving you at the time the document is signed, an employee of the health care provider (other than a chaplain or social worker), or an employee (other than a chaplain or social worker) of an inpatient health care facility in which you are a patient. Valid witnesses acting in good faith are immune from civil or criminal liability.

You should make relatives and friends aware that you have signed the document and the location where it is kept in a safe, easily accessible place until needed. The document may, but is not required to be, filed for safekeeping, for a fee, with the register in probate of your county residence. The fee for this has been set by State statute at $8.00.

You are responsible for notifying your attending physician of the existence of the Declaration. An attending physician who is notified shall make the Declaration part of your medical records. A Declaration that is in its original form, or is a legible photocopy or electronic facsimile copy, is presumed to be valid.

If you have both a Declaration to Physicians and a Power of Attorney for Health Care, the provisions of a valid Power of Attorney for Health Care supersede any directly conflicting provisions of a valid Declaration to Physicians.

Instructions for Declaration Completion

2. ***Definitions***: The following definitions may be helpful in better understanding your Declaration.
   - A. "Attending physician" means a physician licensed under chapter *448* who has primary responsibility for the treatment and care of the patient.
   - B. "Declaration" means a written, witnessed document voluntarily executed by the declarant under §154.03(1), but is not limited in form or substance to that provided in *§154.03(2)*.
   - C. "Department" means the department of health and family services.
   - D. "Feeding tube" means a medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth or other body opening of a qualified patient.
   - E. "Health care professional" means a person licensed, certified or registered under chapter *441*, *448* or *455*.
   - F. "Inpatient health care facility" has the meaning provided under *§50.135(1)* and includes community-based residential facilities, as defined in *§50.01(1)(g)*.
   - G. "Life-sustaining procedure" means any medical procedure or intervention that, in the judgment of the attending physician, would serve only to prolong the dying process but not avert death when applied to a qualified patient. "Life-sustaining procedure" includes assistance in respiration, artificial maintenance of blood pressure and heart rate, blood transfusion, kidney dialysis and other similar procedures, but does not include: (a) The alleviation of pain by administering medication or by performing any medical procedure. (b) The provision of nutrition or hydration.
   - H. "Terminal condition" means an incurable condition caused by injury or illness that reasonable medical judgment finds would cause death imminently, so that the application of life-sustaining procedures serves only to postpone the moment of death.
   - I. "Persistent vegetative state" means a condition that reasonable medical judgment finds constitutes complete and irreversible loss of all of the functions of the cerebral cortex and results in a complete, chronic and irreversible cessation of all cognitive

functioning and consciousness and a complete lack of behavioral responses that indicate cognitive functioning.

J. "Qualified patient" means a declarant who has been diagnosed and certified in writing to be afflicted with a terminal condition or to be in a persistent vegetative state by 2 physicians, one of whom is the attending physician, who have personally examined the declarant, although autonomic functions continue.

3. ***Procedures for Signing a Declaration***

A declaration must be signed by the declarant in the presence of two (2) witnesses. If the declarant is physically unable to sign a declaration, the declaration must be signed in the declarant's name by one of the witnesses or some other person at the declarant's express direction and in his or her presence; such a proxy signing shall either take place or be acknowledged by the by the declarant in the presence of two (2) witnesses.

4. ***Effect of Declaration***

The desires of a qualified patient who is competent supersede the effect of the Declaration at all times. If a qualified patient is incompetent at the time of the decision to withhold or withdraw life-sustaining procedures or feeding tubes, a Declaration executed under this chapter is presumed to be valid.

5. ***Revocation of Declaration***

If a Declaration is revoked, the attending physician shall record this fact in the patient's medical record including the time, date and place of the revocation as well as the time, date and place (if different) that he or she was notified of the revocation. A Declaration may be revoked at any time by the declarant by any of the following methods:

A. By being canceled, defaced, obliterated, burned, torn or otherwise destroyed by the declarant or by some person who is directed by the declarant and who acts in the presence of the declarant.

B. By a written revocation of the declarant expressing the intent to revoke, signed and dated by the declarant.

C. By a verbal expression by the declarant of his or her intent to revoke the declaration. This revocation becomes effective only if the declarant or a person who is acting on behalf of the declarant notifies the attending physician of the revocation.

D. By executing a subsequent declaration.

6. ***Liabilities***

No physician, inpatient health care facility or health care professional acting under the direction of a physician may be held criminally or civilly liable, or charged with unprofessional conduct, for any of the following:

A. Participating in the withholding or withdrawal of life-sustaining procedures or feeding tubes under chapter *154*, subchapter *II*.

B. Failing to act upon a revocation, unless the person or facility has actual knowledge of the revocation.

C. Failing to comply with a declaration, except that failure by a physician to comply with a declaration of a qualified patient constitutes unprofessional conduct if the physician refuses or fails to make a good faith attempt to transfer the qualified patient to another physician who will comply with the declaration.

SECTION I:
DECLARATION TO PHYSICIANS
(*Wisconsin Living Will*)

PLEASE BE SURE YOU READ THE DECLARATION CAREFULLY AND UNDERSTAND IT BEFORE YOU COMPLETE AND SIGN IT

7. I,_____, being of sound mind, voluntarily state my desire that my dying not be prolonged under the circumstances specified in this document. Under those circumstances, I direct that I be permitted to die naturally. If I am unable to give directions regarding the use of life-sustaining procedures or feeding tubes, I intend that my family and physician honor this document as the final expression of my legal right to refuse medical or surgical treatment.

A. If I have a TERMINAL CONDITION, as determined by 2 physicians who have personally examined me, I do not want my dying to be artificially prolonged and I do not want life-sustaining procedures to be used. In addition, the following are my directions regarding the use of feeding tubes (*if you do not initial either line, feeding tubes will be used*):

_____ YES, I want feeding tubes used if I have a terminal condition.
_____ NO, I do not want feeding tubes used if I have a terminal condition.

B. If I am in a PERSISTENT VEGETATIVE STATE, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of life-sustaining procedures (*if you do not initial either line, life-sustaining procedures will be used*):

_____ YES, I want life-sustaining procedures used if I am in a persistent vegetative state.
_____ NO, I do not want life-sustaining procedures used if I am in a persistent vegetative state.

C. If I am in a PERSISTENT VEGETATIVE STATE, as determined by 2 physicians who have personally examined me, the following are my directions regarding the use of feeding tubes (*if you do not initial either box, feeding tubes will be used*):

_____ YES, I want feeding tubes used if I am in a persistent vegetative state.
_____ NO, I do not want feeding tubes used if I am in a persistent vegetative state.

D. Other personal wishes: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

*(**ATTENTION**: you and the two witnesses, below, must sign at the same time)*

8. Signed: _____

Date: _____

Address: _____

Statement and Signatures of Witnesses

9. I believe that the person signing this document is of sound mind. I am an adult and am not related to the person signing this document by blood, marriage or adoption. I am not entitled to and do not have a claim on any portion of the person's estate and am not otherwise restricted by law from being a witness.

10. Witness Signature: _____

Printed Name:_____ Date: _____

Address: _____

11. Witness Signature: _____

Printed Name:_____ Date: _____

Address: _____

*****

DIRECTIVES TO ATTENDING PHYSICIAN

12. This document authorizes the withholding or withdrawal of life-sustaining procedures or of feeding tubes when two (2) physicians, one of whom is the attending physician, have personally examined and certified in writing that the patient has a terminal condition or is in a persistent vegetative state.

13. The choices in this document were made by a competent adult. Under the law, the patient's stated desires must be followed unless you believe that withholding or withdrawing life-sustaining procedures or feeding tubes would cause the patient pain or reduced comfort and that the pain or discomfort cannot be alleviated through pain relief measures. If the patient's stated desires are that life-sustaining procedures or feeding tubes be used, this directive must be followed.

14. If you feel that you cannot comply with this document, you must make a good faith attempt to transfer the patient to another physician who will comply. Refusal or failure to make a good faith attempt to do so constitutes unprofessional conduct.

15. If you know that the patient is pregnant, this document has no effect during her pregnancy.

16. The person making this Living Will may use the following space to record the names of those individuals and health care providers to who he or she has given copies of this document. _____

_____
_____
_____

_____
_____
_____

_____
_____
_____
_____
_____
_____
_____

(If you are interested in more information about the significant terms used in this document, see section §154.01 of the Wisconsin Statutes or the information accompanying this document.)

SECTION II:
POWER OF ATTORNEY FOR HEALTH CARE

Designation of Health Care Agent

(*Pursuant to WSA, Ch.155: §155.01 to §155.80*)

17. **Declaration Introduction**

The Power of Attorney for Health Care form makes it possible for adults in Wisconsin to authorize other individuals (called health care "agents") to make health care decisions on their behalf, should they become incapacitated. It may also be used to make or refuse to make an anatomical gift (donation of all or part of the human body to take effect on or after the death of the donor).

Be sure to read the form carefully and understand it before you complete and sign it.

Talk with the persons you select as you health care agent and the alternate health care agent about you thoughts and beliefs about medical treatment. Neither the health care agent nor the alternate may be your health care provider, an employee of a health care facility in which you are a patient or a spouse of any of those persons, unless he or she is also your relative.

Two witnesses are required. Witnesses must be at least 18 years of age, not related to you by blood, marriage or adoption, and not directly financially responsible for your health care. Witnesses also may not be persons who know they are entitled to or have claim on any portion of your estate. A witness cannot be a health care provider who is serving you at the time the document is signed, an employee of the health care provider (other than a chaplain or social worker), or an employee (other than a chaplain or social worker) of an inpatient health care facility in which you are a patient. Valid witnesses acting in good faith are immune from civil or criminal liability.

An original signed form may be kept on file with your physician. A signed Power of Attorney for Health Care form may also be kept in a safe, easily accessible place until needed. You should make relatives and friends aware that you have created a Power of Attorney for Health Care, and the location of where it is kept. Relatives and friends should also be told whom you select as the health care agent and the alternate. The document may, but is not required to be, filed for safekeeping for a fee with the Register of Probate of your county of residence. The fee for this has been set by State Statute at $8.00. A Power of Attorney for Health Care that is an original signed form, or is a legible photocopy or electronic facsimile copy is presumed to be valid. If you have both a Power of Attorney for Health Care and a Declaration to Physicians, the provisions of a valid Power of Attorney for Health Care supersede any directly conflicting provisions of a valid Declaration to Physicians.

18. ***Definitions***:

The legislature and the Department of Health and Family Services have deemed the following definitions to be of importance to you:

A. "Department" means the department of health and family services.

B. "Feeding tube" means a medical tube through which nutrition or hydration is administered into the vein, stomach, nose, mouth or other body opening of a qualified patient.

C. "Health care" means any care, treatment, service or procedure to maintain, diagnose

or treat an individual's physical or mental condition.

D. "Health care decision" means an informed decision in the exercise of your right to accept, maintain, discontinue or refuse health care.

E. "Health care facility" means a facility as defined in *§647.01(4)*, or any hospital, nursing home, community-based residential facility, county home, county infirmary, county hospital, county mental health center, tuberculosis sanatorium or other place licensed or approved by the Department of Health and Family Services *(under §49.70, §49.71, §49.72, §50.02, §50.03, §50.35, §51.08, §58.05, §252.073, or §252.076, or a facility under §45.365, §51.05, §51.06, §233.40, §233.41, §233.42, or §252.10)*.

F. "Health care provider" means a nurse licensed or permitted under ch.441, a chiropractor licensed under chapter *446*, a dentist licensed under ch.447, a physician, podiatrist or physical therapist licensed or an occupational therapist ro occupational therapy assistant, certified under chapter *448*, a person practicing Christian Science treatment, an optometrist licensed under chapter *449*, a psychologist licensed under chapter *445*, a partnership thereof, a corporation thereof that provides health care services, an operational cooperative sickness care plan *(organized under §185.981 to §185.985)* that directly provides services through salaried employees in its own facility, or a home health agency *(as defined in §50.49(1)(a))*.

G. "Incapacity" means the inability to receive and evaluate information effectively or to communicate decisions to such an extent that the individual lacks the capacity to manage his or her health care decisions.

19. ***Who may sign a Power of Attorney for Health Care?***

An individual who is of sound mind and has attained age 18 may voluntarily execute a Power of Attorney for Health Care. An individual for whom an adjudication of incompetence and appointment of a guardian of the person is in effect under State Statute Chapter 880 is presumed not to be of sound mind.

20. ***Procedures for Signing a Power of Attorney for Health Care***

The principal (person creating the Power of Attorney for Health Care) and the witnesses must all sign the form at the same time.

21. ***When does it take effect?***

Unless otherwise specified in the Power of Attorney for Health Care instrument (form), an individual's Power of Attorney for Health Care takes effect upon a finding of incapacity by two (2) physicians, as defined in *§448.01(5)*, or one physician and one licensed psychologist, as defined in *§448.01(4)*, who personally examine the principal and sign a statement specifying that the principal has incapacity. Mere old age, eccentricity or physical disability, either singly or together, is insufficient to make a finding of incapacity. Neither of the individuals who make a finding of incapacity may be a relative of the principal or have knowledge that he or she is entitled to or has a claim on any portion of the principal's estate. A copy of the statement, if made, shall be appended to the Power of Attorney for Health Care instrument.

22. ***Revocation***

A principal may revoke his or her Power of Attorney for Health Care and invalidate the Power of Attorney for Health Care instrument at any time by doing any of the following:

A. Canceling, defacing, obliterating, burning, tearing, or otherwise destroying the Power of Attorney for Health Care instrument, or directing another in the presence of the principal to so destroy the Power of Attorney for Health Care instrument;

B. Executing a statement, in writing, that is signed and dated by the principal, expressing the principal's intent to revoke the Power of Attorney for Health Care;

C. verbally expressing the principal's intent to revoke the Power of Attorney for Health Care in the presence of two (2) witnesses; or,

D. Executing a subsequent Power of Attorney for Health Care instrument.

The principal's health care provider shall, upon notification of revocation of the principal's Power of Attorney for Health Care instrument, record in the principal's medical record the time, date and place of the revocation as well as the time, date and place (if different) that he or she was notified of the revocation.

23. ***Immunities***

<u>*Facilities and Providers*</u>: No health care facility or health care provider may be charged with a crime, held civilly liable or charged with unprofessional conduct for any of the following:

A. Certifying incapacity under *§155.05(2)*, if the certification is made in good faith based on a thorough examination of the principal;

B. Failing to comply with a Power of Attorney for Health Care instrument or the decision of a health care agent, except that failure of a physician to comply constitutes unprofessional conduct if the physician refused or fails to make a good faith attempt to transfer the principal to another physician who will comply;

C. Complying, in the absence of actual knowledge of a revocation, with the terms of a Power of Attorney for Health Care instrument that is in compliance with chapter *155*; or the decision of a health care agent that is made under a Power of Attorney for Health Care that is in compliance with chapter *155*;

D. Acting contrary or failing to act on a revocation of a Power of Attorney for Health Care, unless the health care facility or health care provider has actual knowledge of the revocation; or

E. Failing to obtain the health care decision for a principal from the principal's agent, if the health care facility or health care provider has made a reasonable attempt to contact the health care agent and obtain the decision but has been unable to do so.

<u>*Health Care Agents*</u>: No health care agent may be charged with a crime or held civilly liable for:

A. Making a decision in good faith under a Power of Attorney for Health Care instrument that is in compliance with ch. 155.

B. No health care agent who is not the spouse of the principal may be held personally liable for any goods or services purchased or contracted for under a Power of

Attorney for Health Care instrument.

24. ***General Provisions***

The making of a health care decision on behalf of a principal under the principal's Power of Attorney for Health Care instrument does not, for any purpose, constitute suicide.

No individual may be required to execute a Power of Attorney for Health Care as a condition for receipt of health care or admission to a health care facility.

No insurer may refuse to pay for goods or services covered under a principal's insurance policy solely because the decision to use the goods or services was made by the principal's health care agent.

POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT

Mandatory Wisconsin Introduction:

NOTICE TO PERSON MAKING THIS DOCUMENT

25. 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 it, 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 also may 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 document 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.
KEEP THIS PAGE WITH YOUR COMPLETED POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT.

POWER OF ATTORNEY FOR HEALTH CARE

26. Document made this _____ day of _____ (*month*), _____ (*year*).

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

27. Be it known that I:
    Full Legal Name: _____
    Date of Birth: _____
    Street Address: _____
    City: _____ County: _____
    State: _____ Zip Code: _____

    ~~ being of sound mind, intend by this document to create a power of attorney for health care. My executing this power of attorney for health care is voluntary. Despite the creation of this power of attorney for health care, I expect to be fully informed about and allowed to participate in any health care decision for me, to the extent that I am able. For the purposes of this document, "health care decision" means an informed decision to accept, maintain, discontinue or refuse any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition. In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

DESIGNATION OF HEALTH CARE AGENT

28. If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate:
    Name of Agent: _____
    Address: _____
    Telephone: Home:_____ Work:_____
    Cell Phone or Pager: _____ E-mail: _____

    ~~to be my health care agent for the purpose of making health care decisions on my behalf.

29. If he or she is ever unable or unwilling to do so, I hereby designate:

Name of Alternate:_____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

~~ to be my alternate health care agent for the purpose of making health care decisions on my behalf. Neither my health care agent nor my alternate health care agent whom I have designated is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient or a spouse of any of those persons, unless he or she is also my relative. For purposes of this document, "incapacity" exists if 2 physicians or a physician and a psychologist who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions. A copy of that statement must be attached to this document.

GENERAL STATEMENT OF AUTHORITY GRANTED

30. Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care agent and believe that he or she understands my philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

If I am unable, due to my incapacity, to make a health care decision, my health care agent is instructed to make the health care decision for me, but my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care agent shall base his or her health care decision on what he or she believes to be in my best interest.

LIMITATIONS ON MENTAL HEALTH TREATMENT

31. My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for the mentally retarded, a state treatment facility or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES OR COMMUNITY-BASED RESIDENTIAL FACILITIES

32. My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

If I have initialed "Yes" to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have initialed "No" to the following, my health care agent may not so admit me:

A. A nursing home:

Yes _____ No _____

B. A community-based residential facility:

Yes _____ No _____

(*If I have not checked either "Yes" or "No" immediately above, my health care agent may admit me only for short-term stays for recuperative care or respite care.*)

PROVISION OF A FEEDING TUBE

33. If I have checked "Yes" to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care agent may not have a feeding tube withheld or withdrawn from me. My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube:

Yes _____ No _____

(*If I have not initialed either "Yes" or "No" immediately above, my health care agent may not have a feeding tube withdrawn from me.*)

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

34. If I have initialed "Yes" to the following, my health care agent may make health care decisions for me even if my agent knows I am pregnant. If I have initialed "No" to the following, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

Health care decision if I am pregnant:

Yes _____ No _____

(*If I have not checked either "Yes" or "No" immediately above, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.*)

STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS

35. In exercising authority under this document, my health care agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are specific desires, provisions or limitations that I wish to state (add more items if needed):

A) _____
_____

B) _____
_____

C) _____
_____

INSPECTION AND DISCLOSURE OF INFORMATION
RELATING TO MY PHYSICAL OR MENTAL HEALTH

36. Subject to any limitations in this document, my health care agent has the authority to do all of the following:

a) Request, review and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records.
b) Execute on my behalf any documents that may be required in order to obtain this information.
c) Consent to the disclosure of this information.

(***The principal and the witnesses all must sign the document at the same time***)
SIGNATURE OF PRINCIPAL
(*Person creating the power of attorney for health care*)

37. Signature _____ Date _____
(*The signing of this document by the principal revokes all previous powers of attorney for health care documents*.)

STATEMENT OF WITNESSES

38. I know the principal 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 declarant is a patient. I am not the principal's health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

39. Witness No. 1:
(*Print*) Name _____ Date _____

Address _____

Signature _____

40. Witness No. 2:
(*Print*) Name _____ Date _____

Address _____

Signature _____

STATEMENT OF HEALTH CARE AGENT AND
ALTERNATE HEALTH CARE AGENT

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

42. Agent's signature _____

Address _____

43. Alternate's signature _____

Address _____

Failure to execute a power of attorney for health care document under chapter *155* of the Wisconsin Statutes creates no presumption about the intent of any individual with regard to his or her health care decisions. This power of attorney for health care is executed as provided in chapter *155* of the Wisconsin Statutes.

ANATOMICAL GIFTS
(*optional*)

44. Upon my death (*initial only <u>one</u>*):

_____ I wish to donate only the following organs or parts:

_____
(*specify the organs or parts*).

_____ I wish to donate any needed organ or part.

_____ I wish to donate my body for anatomical study, if needed.

_____ I refuse to make an anatomical gift. (*If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate*.)

(*Failing to initial any of the lines immediately above creates no presumption about my desire to make or refuse to make an anatomical gift*.)

45. Signature _____ Date _____