

Michigan Durable Power of Attorney:

I _____,
am of sound mind, and I voluntarily make this designation.

I designate _____,
living at _____,
as my patient advocate to make care, custody, and medical treatment decisions for me in the
event I become unable to participate in medical treatment decisions. If my first choice cannot
serve, I designate _____
living at _____
to serve as my successor patient advocate.

The determination of when I am unable to participate in medical treatment decisions shall be
made by my attending physician and another physician or licensed psychologist.

In making decisions for me, my patient advocate shall follow my wishes of which he or she is
aware, whether expressed orally, in a living will, or in this designation.

My patient advocate has authority to consent to or refuse treatment on my behalf, to arrange
medical services for me, including admission to a hospital or nursing care facility, and to pay for
such services with my funds. My patient advocate shall have access to any of my medical
records to which I have a right.

With respect to my care, custody and medical treatment, my advocate shall have the power to
make each and every judgment necessary for the proper and adequate care and custody of my
person, including, but not limited to:

- access and control over my medical information
- selection and discharge of physicians, nurses, therapists, and any other care providers,
and to pay them reasonable compensation with my funds.
- Giving informed consent or an informed refusal on my behalf with respect to any
medical care; diagnostic, surgical or therapeutic procedure; or other treatment of any
type or nature.
- Execution of waivers, medical authorizations and such other approval as may be
required to permit care which I may need, or to discontinue care that I am receiving.

My advocate shall be guided in making such decisions by what I have told my advocate about
personal preferences regarding such care. I understand that such a decision to withhold or
withdraw treatment could or would allow me to die. I acknowledge that such a decision could or
would allow me to die. Other wishes concerning care are the
following: _____

Patient
Initials

This Durable Power of Attorney Healthcare shall not be affected by my disability or incapacity. This Durable Power of Attorney for Healthcare is governed by Michigan law. I may revoke this designation at any time by communicating in any manner that this designation does not reflect my wishes. It is my intent that my family, the medical facility, and any doctors, nurses and other medical personnel involved in my care not be liable for implementing the decisions of my patient advocate or honoring wishes expressed in this designation.

Photostatic copies of this document, after it is signed and witnessed, shall have the same legal force as the original document.

I voluntarily sign this Durable Power of Attorney for Healthcare after careful consideration. I accept its meaning and I accept its consequences.

Signature _____ Date: _____

Your street address _____

City, Michigan, Zip Code _____

Notice Regarding Witnesses:

You must have two adult witnesses who should be disinterested individuals and must not be you or your spouse, parent, child, grandchild, sibling, presumptive heir, physician, patient advocate, an employee of your life or health insurance provider, an employee of a health facility that is treating you, or an employee of a home for the aged.

Statement of Witnesses:

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, and under no duress, fraud or undue influence.

Witness 1 signature _____

Print or type full name _____

Address _____

Witness 2 signature _____

Print or type full name _____

Address _____