PROTECTIVE POWER OF ATTORNEY FOR HEALTH CARE

(Chapter 155 of the Wisconsin Statutes)

WISCONSIN PROTECTIVE POWER OF ATTORNEY FOR HEALTH CARE

NOTICE TO PERSON MAKING THIS DOCUMENT (Required by Wis. Stat. 155.30(1))

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 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.

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

CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

By this document, I intend to create a durable power of attorney for health care in which I appoint a health care agent for the purpose of making health care decisions for me in the event I am unable to make health care decisions for myself due to incapacity and only for the duration of such incapacity.

DESIGNATION OF HEALTH CARE AGENT(S)

I,

Name: _____

Address: _____

Date of birth: _____

do hereby designate

Name: _____

Address: _____

Telephone: _____

to be my health care agent.

If he/she is ever unable or unwilling to be my health care agent, I hereby designate

Name: _____

Address: _____

Telephone: _____

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

GENERAL STATEMENT OF AUTHORITY GRANTED

Subject to the directions, special provisions, and limitations in this document, I hereby grant my agent full authority to make health care decisions for me if 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. I expect to be fully informed about and allowed to participate in any health care decisions for me to the extent that I am able.

Nothing in this document shall authorize anyone to approve or commit any action or omission which will cause my death. While certain forms of care and treatment may be futile in curing a disease or injury, care or treatment which sustains life is not futile. I reject both euthanasia and assisted suicide, which are contrary to my belief that human bodily life is inherently good and not merely instrumental to other goods.

DIRECTIONS, SPECIAL PROVISIONS, AND LIMITATIONS

I have carefully discussed my beliefs, principles, and health care preferences with my agent. I trust my agent to make health care decisions for me based on my desires as stated in this document or which I have otherwise expressed to my agent.

1. The meanings of the words used in this document are those which I have discussed with my agent and my agent's interpretation of them is controlling. "Benefit" refers to my physical health, comfort, and longevity and shall not be determined by a quality of life standard. I oppose suicide and euthanasia and direct that nothing in this document be interpreted to request or authorize providing or withholding treatment or support for the purpose of causing my death.

2. My agent has the authority to request, review, and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records, and to consent to the disclosure of this information.

3. I direct that nutrition and hydration, whether orally ingested or administered through a tube, be provided to me unless death is inevitable and imminent from a cause independent of nutrition and hydration so that the effort to sustain my life is futile or unless I am unable to assimilate food and fluids.

4. I direct my agent to request, require, and consent to care, treatment, and procedures which are appropriate to my condition and offer a reasonable hope of benefit.

5. I direct my agent to withhold or withdraw consent to care, treatment, and procedures which are not appropriate to my condition and do not offer a reasonable hope of benefit.

6. I authorize my agent to determine whether or not a Do Not Resuscitate (DNR) order is appropriate for me.

7. I authorize my agent to admit me to or discharge me from a nursing home or community-based residential facility under the conditions I have expressed to my agent.

8. If I am pregnant, I direct that every effort be made to save the life of my child.

9. My agent shall not be held personally liable for any medical goods or services purchased or contracted for in compliance with my wishes regarding medical care and treatment, except as required by law.

10. I direct my agent to firmly protect my rights and best interests, taking legal action if necessary.

11. It is my express wish that no one petition the court to remove or replace my agent unless it can be clearly shown that my agent has failed or refused to act in accord with these directions, special provisions, and limitations.

These instructions are always a part of my Protective Power of Attorney for Health Care document and are binding on my agent and all of my health care providers. Only this document which bears my original signature shall be deemed legally valid.

IMMUNITIES

My health care agent may not be held criminally or civilly liable for making a decision in accord with this document. No health care facility or provider may be held criminally or civilly liable for following the directions of my health care agent acting in accord with this document.

REVOCATION, AMENDMENTS, AND ADDENDUMS

By signing this power of attorney for health care, I revoke any prior health care directive that I have made. This power of attorney shall remain in force and effect until revoked by me in the presence of two witnesses. Amendments and addendums to this document shall be made in writing by me personally (and not by my agent or a health care provider) and they shall be attached to the original of this document. My subsequent physical or mental disability, incapacity, or incompetency shall not affect this durable power of attorney nor diminish the authority of my agent.

GUARDIAN

If it becomes necessary to appoint a guardian for me, I nominate, in the same order of preference, my agent and alternate agent. I direct that this document be treated as my "written instrument" under Sec. 880.09(7), Wisconsin Statutes, authorizing such nomination.

SIGNATURE OF PRINCIPAL

I, being of sound mind, intend this document to create a power of attorney for health care. I am executing this document voluntarily.

Signature _____ Date _____

STATEMENT OF WITNESSES

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 principal 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. I signed this statement in the conscious presence of the principal and saw the principal sign this document.

Witness No. 1:

(print) Name_____ Date _____

Address _____

Signature _____

Witness No. 2:

(print) Name _____ Date _____

Address _____

Signature _____

STATEMENT OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT

I understand that the principal (signer of this power of attorney for health care), _____, has designated me to be his or her health care agent or alternate health care agent if he or she is ever found to lack the capacity to make health care decisions for himself or herself. I further understand that my authority to make such decisions is only operative for the duration of the principal's incapacity. The principal has discussed his or her desires regarding health care decisions with me.

Agent's signature _____

Address _____

Alternate agent's signature _____

Address _____

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Anatomical Gifts: Wisconsin Protective Power of Attorney for Health Care Addendum

Dear PPAHC Recipient,

Billboards plead, "Give the Gift of Life." News stories spotlight the shortage of organs available for transplantation and the tragedy of people who die on waiting lists. Everyone applying for a license or permit to drive – even minors – is given the "opportunity" to check "YES" to organ donation; the same for everyone completing a health care directive provided by the State of Wisconsin or their local hospital.

Absent from the campaign to enlist organ donors are the facts necessary for people like you to make fully informed and morally sound decisions about organ donation. Pro-Life Wisconsin (PLW) is working to fill that gap by providing both educational and practical help. Therefore, enclosed is an Addendum to the Protective Power of Attorney for Health Care (PPAHC) document which you received from PLW. **By signing this Addendum, you refuse to donate vital organs**. This is a very important addition to your PPAHC. Let me explain.

The vast majority of vital organs taken for transplantation come from patients who have been declared "brain dead." Numerous reports about people who have recovered consciousness after firm diagnoses of "brain death" provide ample evidence that **"brain death" is not true death**. Ponder Zack Dunlap's case. Last November, this 21-year-old Oklahoman flipped over on his 4-wheeler and sustained catastrophic brain injuries. Thirty-six hours later, doctors declared him "brain dead." Preparations to harvest his organs were halted when Zack's cousin, a nurse, scraped his foot with a pocket knife and Zack jerked his foot away. He is now walking and talking.

For a vital organ to be suitable for transplantation, it must come from a living person. Organ removal does not benefit the donor. **It causes his or her death.** [For more information, see the enclosed brochures: *Medical Decision Making: Organ Donation*.]

The Addendum is a refusal to donate vital organs after a diagnosis of "brain death" or "cardiac death." Vital organs, also called vascularized organs, are organs that require continuous circulation of blood to remain useful for purposes of transplantation. Your health care agent is granted the authority to make decisions about the donation of other organs or tissues that can be taken after he/she is certain you are truly dead. It is beyond the scope of this Addendum to address a competent person's voluntary donation of organs, such as the donation of one of two healthy kidneys, a lobe of a liver or a lobe of a lung.

This year, the Wisconsin Anatomical Gift Act was revised, making it imperative that you explicitly refuse to donate vital organs. Under Section 6 of this revised Act, everyone "who is dead or near death" is a "prospective donor" unless he or she has refused to make an anatomical gift, meaning it is presumed that you intend to be an organ donor unless you have

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signed a written refusal. And that presumption means that a prospective donor who is declared "dead" or who is "near death" can be subjected to measures that may actually do harm to the still living prospective donor in order to "ensure the medical suitability" of an organ. **It is appalling to think that organs for transplantation have become more important than the person to whom they belong!**

Please strongly consider signing the enclosed Addendum for your protection and, once signed, please attach it to your original completed PPAHC. Thank you and God bless you.

Sincerely,

Dan Miller
State Director

PROTECTIVE POWER OF ATTORNEY FOR HEALTH CARE ADDENDUM

I, _____, refuse to make an anatomical gift of any vascularized organ (vital organ). I do not want any vascularized organ (vital organ) taken for transplantation or for any other purpose. My agent, appointed in my Power of Attorney for Health Care, may make all other decisions regarding anatomical gifts after my agent is certain that I am dead.

Signature:_____Date_____
Witness:_____Date_____
Witness:_____Date_____