PRINT YOUR NAME AND ADDRESS

PRINT THE NAME, ADDRESS, AND PHONE NUMBER OF YOUR AGENT

ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE

MY POWER OF ATTORNEY FOR HEALTH CARE

THIS POWER OF ATTORNEY REVOKES ALL PREVIOUS POWERS OF ATTORNEY FOR HEALTH CARE. (You must sign this form and a witness must also sign it before it is valid)

My name (Print your full name): _____

My address: _____

I WANT THE FOLLOWING PERSON TO BE MY HEALTH CARE AGENT

(an agent is your personal representative under state and federal law):

(Agent name) _____

(Agent address) _____

(Agent phone number) _____

MY AGENT CAN MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING:

(i) Deciding to accept, withdraw or decline treatment for any physical or mental condition of mine, including life-and-death decisions.

(ii) Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.

(iii) Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.

(iv) Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue or whole body donation, autopsy, cremation, and burial.

The above grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures.

CHECK ONE OF THE TWO BOXES

YOU MAY CHECK ONE OF THE TWO BOXES, OR YOU MAY DECLINE TO CHECK EITHER

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I AUTHORIZE MY AGENT TO (please check any one box):

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. (If no box is checked, then the box above shall be implemented.) OR

☐ Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes. Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements.

SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES (optional):

☐ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.

☐ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

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SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically in this form.

LIST ANY LIMITS TO AGENT'S POWERS

_____

_____

SIGN AND DATE HERE

My signature: _____

Today's date: _____

HAVE YOUR WITNESS AGREE TO WHAT IS WRITTEN BELOW, AND THEN COMPLETE THE SIGNATURE PORTION:

I am at least 18 years old. (check one of the options below):

CHECK ONE OF THE TWO BOXES

☐ I saw the principal sign this document, or

☐ the principal told me that the signature or mark on the principal signature line is his or hers.

RESTRICTIONS ON WITNESSES

I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent, or the successor agent(s) by blood, marriage, or adoption. I am not the principal's physician, mental health service provider, or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the health care facility where the principal is a patient or resident.

HAVE WITNESS PRINT NAME AND ADDRESS AND SIGN HERE

Witness printed name: _____

Witness address: _____

Witness signature: _____

Today's date: _____

NOTARY SECTION (NOT required for Illinois) _____

State of _____ County of _____. Before me, the undersigned notary public, this day, personally appeared to me known, who being duly sworn according to law. Subscribed and sworn before me this _____day of _____

_____ _____

Notary Public My Commission expires

NAME YOUR SUCCESSOR AGENTS HERE

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SUCCESSOR HEALTH CARE AGENT(S) (optional):

If the agent I selected is unable or does not want to make health care decisions for me, then I request the person(s) I name below to be my successor health care agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names):

_____

_____

(Successor agent #1 name, address and phone number)

_____

_____

(Successor agent #2 name, address and phone number)