MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I, ____, Declarant,

Print or Type Your Name

hereby appoint:

Name of Agent

Agent's Home Telephone Number

Agent's Work Telephone Number

Agent's Home Address

as my agent to make health care decisions for me if and when I am unable to make my own health care decisions. This gives my agent the power to consent to giving, withholding or stopping any health care, treatment, service or diagnostic procedure. My agent also has the authority to talk with health care personnel, get information and sign forms necessary to carry out those decisions.

If the person named as my agent is not available or is unable to act as my agent, then I appoint the following person(s) to serve in the order listed below:

2. ______________________________ ______________________________

AGENT Work Phone Home Phone

3. ______________________________ ______________________________

AGENT Work Phone Home Phone

By this document I intend to create a Medical Durable Power of Attorney which shall take effect upon my incapacity to make my own health care decisions and shall continue during that incapacity. My agent shall make health care decisions as I may direct below or as I make known to him or her in some other way. If I have not expressed a choice about the health care in question, my agent shall base his/her decision on what he/she believes to be in my best interest.

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(A) Statement of desires concerning life-prolonging care, treatment, services and procedures:

(B) Special provisions and limitations:

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT:

Signature of Person Creating Medical Durable Power of Attorney

____

Date ________________________

OPTIONAL, BUT RECOMMENDED

Colorado law does not require this instrument to be witnessed; however, the Advance Directives Coalition recommends the signature of a witness.

WITNESS:______________________________

Signature:______________________________

Home Address:____________________

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Date:_________________________