INDIANA LIVING WILL (ADVANCE HEALTH CARE DIRECTIVE)

and

MEDICAL POWER OF ATTORNEY

GENERAL INFORMATION

This Living Will (Advance Health Care Directive) and Medical Power of Attorney allows you to designate an agent (attorney-in-fact) who will have the power to make medical decisions in the event that you cannot do so yourself. This document also provides a means of describing your specific instructions to your agent regarding your health care and end-of-life care. The agent you select is required to act in accordance with your instructions as provided in this document or otherwise stated elsewhere.

Unless you instruct otherwise within this document, this document gives your agent the power to consent to the cessation of treatment necessary for maintaining your life, and the power to instruct your doctor to not provide treatment.

You have the right to give informed consent to decisions or procedures, and make medical and other health care decisions for yourself, even though you execute this document. No treatment may be provided to you if you object to such treatment, including procedures and/or care which are integral to the preservation of your life.

You may give your agent the authority to consent, object to, or to withdraw previously given consent to any health care services, including but not limited to medications, treatments, or procedures necessary to diagnose, treat, or maintain a physical or mental condition. However, your agent s authority is subordinate to any instructions, directions, or limitations which you state in this document. You may also define which types of treatment you do not wish to receive. Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document. If your agent acts contrary to your desires in this document, authorizes illegal treatments or care, or acts in a way that is not in your best interest, a court can remove your agent s power and replace your agent.

Unless limited in this document, the power granted to your agent will last until it is revoked, a specified term in the document has expired, or you pass away.

If you revoke this document or the appointment of any agent, you should notify your agent and your health care provider of the revocation, either orally or in writing.

Unless you provide instructions to the contrary in this document, this document gives your agent the power after your death to direct how your remains are disposed of, authorize an autopsy, or donate your organs, tissues, or parts for various purposes.

LIVING WILL/ADVANCE HEALTH CARE DIRECTIVE

Declaration made this ____ day of _____, 20___, I, _____ (name), presently residing at _____ _____ (address) willfully and voluntarily make known my desires for health care and end-of-life care as described below.

HEALTH CARE

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, my desires for care are as follows:

I desire that certain medical treatments not be used under any circumstances, and I do hereby declare that, if at any time I am incapacitated, the following shall not be used:

_____ (initial) Cardiopulmonary Resuscitation (CPR)

_____ (initial) Nutrition/Hydration by tube or IV

_____ (initial) Ventilation machine/breathing apparatus

_____ (initial) Dialysis

_____ (initial) Blood transfusions

_____ (initial) Organ transplants

_____ (initial) ANY artificial life-sustaining treatment

END-OF-LIFE CARE

I desire that my life shall not be artificially extended if I am incapacitated and:

_____ (initial) I am not able to communicate my needs and am totally dependent on others for daily tasks such as eating, toileting, hygiene, and the like, or

_____ (initial) My mental condition has deteriorated to the point that I cannot make my wishes known and/or I cannot recognize my loved ones, or

_____ (initial) I have an end stage condition, or

_____ (initial) I have a terminal condition, or

_____ (initial) My primary physician and one other physician have determined that there is no reasonable medical probability of my recovery from a vegetative state,

THEN I desire that my health care provider(s) withhold life-prolonging medications or procedures which artificially prolong the process of my death, and allow me to die naturally with the only medical intervention being the performance of a medical procedure or administration of medication necessary to provide me with comfort care or palliative care.

My family and physician shall treat this document as the expression of my legal right to refuse health care, surgical, or medical treatment and to accept the consequences for such refusal, and shall honor the decisions in this document as if I were able to make them at the time.

I am emotionally and mentally competent to make this declaration and I understand the full consequences of it.

Additional Instructions (optional):

_____
_____
_____
_____
_____
_____
_____

MEDICAL POWER OF ATTORNEY

1. I, _____ (name) (the "Principal") do hereby nominate, constitute, and appoint the following person as my as my true and lawful attorney-in-fact ("agent"), to act for me and in my name, place, and stead, and for my use and benefit for health care purposes:

Name: _____

Address: _____
_____

Phone: _____

If the person I have designated above is unable or unwilling to carry out the provisions of this declaration, then I designate the following person as my substitute agent to carry out the provisions of this declaration:

Name: _____

Address: _____

_____

Phone: _____

If the original agent or a substitute agent is unable to act, then, in such case, one (1) of the following documents shall be attached to this Medical Power of Attorney: a resignation or declination to serve signed by the previous agent; a written and signed statement from a licensed physician that the previous named agent is physically or mentally incapable of serving; a certified court order as to the incapacity or inability of the previous named agent to serve; or a certified death certificate of the previous named agent. Third parties who deal with the substitute agent shall be entitled to rely on the original power of attorney instrument, or a photocopy thereof, with any such document attached.

Subject to any instructions set forth above, in the event of my incapacity, my agent will have full power and authority to make health care decisions for me, including, but not limited to, the power and authority to do the following:

A. Employment of Health Care Personnel. To employ such physicians, dentists, nurses, therapists, and other professionals or non-professionals as my agent may deem necessary or appropriate for my physical or mental well-being; and to pay from my funds reasonable compensation for all services performed by such persons;

B. Gain Access to Medical and Other Personal Information. To request, review, and receive any information, verbal or written, regarding my personal affairs or my physical or mental health, including medical and hospital records, and to execute any releases or other documents that may be required in order to obtain this information;

C. Consent or Refuse Consent to Medical Care. To give consent or withhold consent to diagnostic procedures, to medical care, surgery, or any other medical procedures or tests involving my physical or mental condition; to arrange for my hospitalization, convalescent care, or home care; and to revoke, withdraw, modify, or change consent to such medical care, surgery, or any other medical procedures or tests, hospitalization, convalescent care, or home care, which I or my agent may have previously allowed or consented to which may have been implemented due to emergency conditions. I ask my agent to be guided in making such decisions by whatever I may have told my agent about my personal preferences regarding such care. Based on those same preferences, my agent may also summon paramedics or other

emergency medical personnel and seek emergency treatment, or choose not to do so, as my agent deems appropriate given my wishes and medical status at the time of the decision. My agent is authorized, when dealing with hospitals and physicians, to sign documents titled or purporting to be a "refusal to permit treatment" and "leaving hospital against medical advice," as well as any necessary waivers of or releases of liability required by the hospitals or physicians to implement my wishes regarding medical treatment or non-treatment;

D. Refuse Extreme Life-Prolonging Procedures. To request that any extraordinary medical care, surgery, procedure, or test designed to artificially prolong my life not be instituted or be discontinued, including (but not limited to) cardiopulmonary resuscitation, the implantation of a cardiac pacemaker, renal dialysis, parenteral feeding, the use of respirators or ventilators, nasogastric tube use, endotracheal tube use, and organ transplants. My agent should try to discuss the specifics of any such decision with me if I am able to communicate in any manner. If I am unconscious, comatose, senile, or otherwise unreachable by such communication, my agent should make the decision guided by any preferences which I may have previously expressed and the information given to the physician treating me as to my medical diagnosis and prognosis. In making such decisions, I want my agent to consider the relief of suffering and the quality as well as the extent of the possible extension of my life. My agent may specifically request and concur with the writing of a "no-code" (do not resuscitate) order by the attending or treating physician;

E. Refuse Nourishment or Hydration. To require, if I have been in an irreversible coma for thirty (30) days or more, as diagnosed by my treating physician, that procedures used to provide me with nourishment and hydration (including, for example, parenteral feeding, intravenous feedings, misting, and endotracheal or nasogastric tube use) not be instituted or, if previously instituted, to require that they be discontinued, but only if my treating physician also determines that I will not experience pain as a result of the withdrawal of nourishment or hydration;

F. Provide Relief from Pain. To consent to and to arrange for the administration of pain-relieving drugs of any type, or other surgical or medical procedures calculated to relieve my pain even though their use may lead to permanent physical damage, addiction, or even hasten the moment of (but not intentionally cause) my death. My agent may also consent to and arrange for unconventional pain-relief therapy such as biofeedback, guided imagery, relaxation therapy, acupuncture, skin stimulation, or cutaneous stimulation, and other therapies which I or my agent believes may be helpful to me;

G. Blood Transfusions. To refuse to accept a blood transfusion on my behalf as part of any hospital procedure unless either (i) I donated the blood myself prior to such procedure or (ii) the donated blood has been tested for any and all infectious diseases, specifically, hepatitis and AIDS;

H. Arrange My Cremation or Burial and Make Anatomical Gifts. To make arrangements for my cremation or funeral and burial, as my agent may elect, taking into consideration my wishes, including the purchase of the burial plot and marker, if applicable, and such other related arrangements, including anatomical gifts, as my agent deems advisable, being guided by any wishes or preferences which I may have previously expressed; and

I. Execute Documents, Enter into Contracts and Pay Reasonable Compensation or Costs in Implementing the Above Powers. To sign, execute, deliver, acknowledge, and make declarations in any document or documents that may be necessary, desirable, convenient, or proper in order to exercise any of the powers described above; to enter into contracts; and to pay from my funds reasonable compensation or costs in the exercise of any such powers.

J. Personal Care Decisions. To decide about personal care on my behalf, to decide about where I will live, choose my clothing, receive my mail, care for my personal belongings, and care for my pet(s), if any, and to make all other decisions of a personal nature not included in the description of health care.

2. This Medical Power of Attorney shall become effective only upon the incapacity of the Principal, as determined and evidenced by a written certificate or statement of the Principal's treating physician, stating that the Principal lacks substantial capacity to make informed health care decisions on the Principal's own behalf. The powers granted herein to the agent shall continue notwithstanding such incapacity and shall cease when the Principal is deemed to have regained capacity as determined and evidenced by the written certificate or statement of the attending physician.

When in the process of determining my incapacity (as it relates to this instrument, or any trust agreement or durable general power of attorney executed by me), all individually identifiable health information and medical records may be released under the HIPAA Release Authority granted under paragraph 3, to the person nominated as my agent, including any written opinion relating to my incapacity that the person so nominated may have requested. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164, and applies even if that person is not yet serving as my agent.

3. My agent shall have the same rights as I now have regarding the use of, and disclosure of, my medical records and/or individually identifiable health information, as well as any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164. I authorize any medical service or information providers that have provided treatment or services to me, or that have paid for (or are seeking payment from me) for such services, including but not limited to: physicians, health care professionals, dentists, health plans, hospitals, clinics, laboratories, pharmacies, other health care

professionals, insurance companies of any kind, the Medical Information Bureau Inc., or any other health care clearinghouse, to disclose and release to my appointed agent, without restriction of any kind, all of my health records and any documents containing individually identifiable health information which pertain to any past, present, or future medical or mental health condition of mine, including all information relating to the diagnosis and treatment of mental illness, drug or alcohol abuse, HIV, AIDS, and/or sexually transmitted diseases.

The authority given to my agent does not expire and shall be invalid only in the event that I revoke the authority in writing and deliver such revocation to my health care provider. The authority given to my agent in this document shall supersede any prior agreement that I may have made to restrict access to, or disclosure of, my individually identifiable health information.

4. My agent shall exercise the powers granted under this Medical Power of Attorney in accordance with any instructions set forth above in my Living Will and my wishes to the extent otherwise known to my agent. To the extent my wishes are unknown, my agent shall exercise the powers granted under this power of attorney in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

5. I hereby ratify and confirm all that my agent shall lawfully do or cause to be done by virtue of this Power of Attorney and hold harmless any person or entity who suffers loss or liability from reliance upon such lawful exercise of this Medical Power of Attorney.

6. If a conservator of my person needs to be appointed for me by a court, I nominate my agent designated in this document. If my agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

7. Only one (1) original of this instrument has been executed. My agent is authorized to make photocopies of this instrument and any attached documents (such as statements of incapacity) as frequently and in such quantities as my agent deems appropriate. Each photocopy shall have the same force and effect as the original, and all parties dealing with my agent are authorized to rely fully on any such photocopy showing the principal's signature thereon.

8. I revoke all prior powers of attorney for health care (but not durable general powers of attorney for asset management), living wills, and directives to physicians that I may have executed. I retain the right to revoke or amend any portion of this instrument and to substitute other agents in place of the agents appointed in this instrument.

9. If any of the provisions of this instrument is invalid for any reason, such invalidity shall not affect any of the other provisions of this instrument, and all invalid provisions shall be fully disregarded.

10. All questions pertaining to validity, interpretation, and administration of this instrument shall be determined in accordance with the laws of my state of residence.

11. This instrument may be revoked or terminated at any time by the Principal. This instrument will exist for an indefinite period of time unless revoked or terminated.

IN WITNESS WHEREOF, I have hereunto set my hand on:

Dated: _____, 20__

_____
(signature)

_____
(printed name)

You must sign this document before two independent witnesses to witness and acknowledge your signature.

WITNESS ACKNOWLEDGMENT

We declare under penalty of perjury (1) that the individual who signed or acknowledged this Living Will/Medical Power of Attorney is personally known to us, or that the individual's identity was proven to us by convincing evidence, (2) that the individual signed or acknowledged this Living Will/Medical Power of Attorney in our presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that neither of us is a person appointed as agent by this Living Will/Medical Power of Attorney, and (5) Neither of us is the individual's health care provider nor an employee of that health care provider, nor an operator or employee of an operator of a community care facility or a residential care facility for the elderly.

Signatures of Witnesses:

First Witness

_____ Print name

_____ Address

_____ City, State

_____ Signature

_____ Date

Second Witness

_____ Print name

_____ Address

_____ City, State

_____ Signature

_____ Date