HEALTH CARE POWER OF ATTORNEY AND LIVING WILL

I, ___________________, as **Principal**, designate ______________________as my **Agent** for all matters relating to my health care, including without limitation, full power to give or refuse consent to all medical, surgical, hospital and related health care. This power of attorney is effective on my inability to make or communicate health care decisions. All of my **Agen**t's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

If ___________________**(Agent)** is unwilling or unable to serve or continue to serve, I hereby appoint _____________________as my **Successor**. If____________________is unwilling or unable to serve or continue to serve as my **Successor**, then _________________________shall serve as **Successor Agent**.

In the event a guardian is to be appointed for Principal by Court proceedings, I hereby nominate my **Agent** to serve in such capacity.

This Power of Attorney and Living Will is intended to be valid in any jurisdiction in which it is presented.

Any physician, hospital or other health-care provider honoring this Power of Attorney and Living Will is hereby fully released from liability while acting pursuant to the direction of my **Agent**.

I, ______________________ **(Principal)** being of sound mind, willfully and voluntarily make known my desires. If I have a terminal condition or any irreversible coma or a persistent vegetative state that my doctors reasonably feel to be irreversible or incurable:

I DO ☐ DO NOT ☐ want my life to be prolonged and I DO ☐ DO NOT ☐ want life-sustaining treatment, beyond comfort care, that would serve only to artificially delay the moment of my death. I DO ☐ DO NOT ☐ want the medical care necessary to provide care that would keep me comfortable. I DO ☐ DO NOT ☐ want the following if it would serve only to artificially delay the moment of my death:

(a) cardiopulmonary resuscitation;

(b) artificially administered food and fluids;

(c) assisted respiration or ventilation (breathing by machine);

(d) blood transfusion;

(e) medications when the purpose is to cure or control life-threatening conditions rather than control pain (for example: antibiotics, chemotherapy);

(f) surgeries that prolong life but do not cure all life-threatening conditions;

(g) any other procedures that prolong my life.

I DO ☐ DO NOT ☐ want to be given medication to eliminate pain, even if my death is hastened or this causes a drug dependence.

This health care directive is made under Arizona Revised Statutes §§ 36-3221, 36-3261, and 36-3262, and continues in effect for all whom may rely on it except those to whom I have given notice of its revocation.

This Power of Attorney shall become effective upon the disability of the **Principal**, which disability shall be established by annexing hereto the sworn statement of a physician setting forth that he or she has examined the **Principal** and believes the **Principal** to be unable to make or communicate responsible decisions concerning the Principal's own care or treatment by reason of the **Principal'**s mental illness, mental disorder, extreme physical disability or any other debilitating or disabling cause.

__________________________ ____

Date **Principal**

I, ___________________________________, am an adult and affirm that I was present when the above principal dated and signed or marked this Health Care Power of Attorney and Living Will, and that the **Principal** appeared to be of sound mind and free from duress at the time of execution of the Health Care Power of Attorney and Living Will. I am not designated to make medical decisions on the **Principal's** behalf. I am not directly involved with the provision of health care to the principal at the time that this Health Care Power of Attorney and Living Will is executed. I am not related to the **Principal** by blood, marriage, or adoption, and I am not entitled to any part of the **Principal's** estate by Will or by operation of law at the time that this Health Care Power of Attorney and Living Will is executed.

In the event the person acknowledging this Health Care Power of Attorney and Living Will is physically unable to sign or mark this document, I verify that the principal directly indicated to me that the Health Care Power of Attorney and Living Will expresses his/her wishes that the **Principal** intends to adopt this Health Care Power of Attorney and Living Will at this time.

____

Signature of Witness

____

Witness Name Printed

Witness Address:

____

____

STATE OF ARIZONA)
) ss.
COUNTY OF PIMA)

The foregoing instrument was acknowledged before me this ________day of ___________, 20___ by _______________Principal.

____

Notary Public

My Commission Expires:

PHYSICIAN AFFIDAVIT

I, Dr. ____________________________________, have reviewed this Health Care Power of Attorney and Living Will and have discussed with __________________(**Principal**) any questions regarding the probable medical consequences of the treatment choices provided in the documents. This discussion with __________________(**Principal**) occurred on (Date)__________________, 20___.

I have agreed to comply with the provisions of this directive.

____
Signature of Physician

____
Name of Physician

197769

THIS HEALTH CARE POWER OF ATTORNEY AND LIVING WILL IS A BINDING LEGAL DOCUMENT. IF NOT UNDERSTOOD, PLEASE CONSULT AN ATTORNEY.

Furnished Compliments of:

Mesch, Clark & Rothschild, P.C.
ATTORNEYS AT LAW
259 North Meyer Avenue

Tucson, Arizona 85701