DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(RHODE ISLAND HEALTH CARE ADVANCE DIRECTIVE)

I, _____,
(Insert your name and address)
am at least eighteen (18) years old, a resident of the State of Rhode Island, and understand this document allows me to name another person (called the health care agent) to make health care decisions for me if I can no longer make decisions for myself and I cannot inform my health care providers and agent about my wishes for medical treatment.

PART I: APPOINTMENT OF HEALTH CARE AGENT
THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS
FOR ME IF I CAN NO LONGER MAKE DECISIONS

Note: You may not appoint the following individuals as an agent:

(1) your treating health care provider, such as a doctor, nurse, hospital, or nursing home,
(2) a nonrelative employee of your treating health care provider,
(3) an operator of a community care facility, or
(4) a nonrelative employee of an operator of a community care facility.

When I am no longer able to make decisions for myself, I name and appoint _____ to make health care decisions for me. This person is called my health care agent.

Telephone number of my health care agent: _____
Address of my health care agent: _____
_____

You should discuss this health care directive with your agent and give your agent a copy.

(OPTIONAL)
APPOINTMENT OF ALTERNATE HEALTH CARE AGENTS:

You are not required to name alternative health care agents. An alternative health care agent will be able to make the same health care decisions as the health care agent named above, if the health care agent is unable or ineligible to make health care decisions for you. For example, if you name your spouse as your health care agent and your marriage is dissolved, then your former spouse is ineligible to be your health care agent.

When I am no longer able to make decisions for myself and my health care agent is not available, not able, loses the mental capacity to make health care decisions for me, becomes ineligible to act as my agent, is not willing to make health care decisions for me, or I revoke the person appointed as my agent to make health care decisions for me, I name and appoint the following persons as my agent to make health care decision for me as authorized by this document, in the order listed below:

_____ My Initials

My **First Alternative Health Care Agent**: _____
Telephone number of my first alternative health care agent: _____
Address of my first alternative health care agent: _____
_____

My **Second Alternative Health Care Agent**: _____
Telephone number of my second alternative health care agent: _____
Address of my second alternative health care agent: _____
_____

My health care agent is automatically given the powers I would have to make health care decisions for me if I were able to make such decisions. Some typical powers for a health care agent are listed below in (A) through (H). My health care agent must convey my wishes for medical treatment contained in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest. A court can take away the power of an agent to make health care decisions for you if your agent:

(1) Authorizes anything illegal,
(2) Acts contrary to your known wishes, or
(3) Where your desires are not known, does anything that is clearly contrary to your best interest.

Whenever I can no longer make decisions about my medical treatment, my health care agent has the power to:

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatments, services, tests, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about mental health treatment.
(B) Advocate for pain management for me.
(C) Choose my health care providers, including hospitals, physicians, and hospice.
(D) Choose where I live and receive health care which may include residential care, assisted living, a nursing home, a hospice, and a hospital.
(E) Review my medical records and disclose my health care information, as needed.
(F) Sign releases or other documents concerning my medical treatment.
(G) Sign waivers or releases from liability for hospitals or physicians.
(H) Make decisions concerning participation in research.

If I DO NOT want my health care agent to have a power listed above in (A) through (H) OR if I want to LIMIT an power in (A) through (H), I must say that here:

_____
_____
_____
_____

_____ My Initials

PART II: HEALTH CARE INSTRUCTIONS

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

Many medical treatments may be used to try to improve my medical condition in certain circumstances or to prolong my life in other circumstances. Many medical treatments can be started and then stopped if they do not help. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start the heart, surgeries, dialysis, antibiotics, and blood transfusions. The back inside page has more information about life-support measures.

OPTIONAL -FOR DISCUSSION PURPOSES

A discussion of these questions with your health care agent may help him or her make health care decisions for you which reflect your values when you cannot make those decisions.

These are my views which may help my agent make health care decisions:

1. Do you think your life should be preserved for as long as possible? Why or why not?

_____
_____
_____

2. Would you want your pain managed, even if it makes you less alert or shortens your life?

_____
_____
_____

3. Do your religious beliefs affect the way you feel about death? Would you prefer to be buried or cremated?

_____
_____
_____

4. Should financial considerations be important when making a decision about medical care?

_____
_____
_____

5. Have you talked with your agent, alternative agent, family and friends about these issues?

_____
_____
_____

_____ My Initials

Here are my desires about my health care to guide my agent and health care providers.

1. If I am close to death and life support would only prolong my dying:

INITIAL ONLY ONE:
_____ I want to receive a feeding tube.
_____ I DO NOT WANT a feeding tube.

INITIAL ONLY ONE:
_____ I want all life support that may apply.
_____ I want NO life support.

2. If I am unconscious and it is very unlikely that I will ever become conscious again:

INITIAL ONLY ONE:
_____ I want to receive a feeding tube.
_____ I DO NOT WANT a feeding tube.

INITIAL ONLY ONE:
_____ I want all other life support that may apply.
_____ I want NO life support.

3. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

INITIAL ONLY ONE:
_____ I want to receive a feeding tube.
_____ I DO NOT WANT a feeding tube.

INITIAL ONLY ONE:
_____ I want all life support that may apply.
_____ I want NO life support.

Additional statement of desires, special provisions, and limitations regarding health care decisions *(More space is available on page 8)*:

_____

_____

ORGAN DONATION

_____ In the event of my death, I request that my agent inform my family or next of kin of my desire to be an organ and tissue donor for **transplant**. *(Initial if applicable)*

_____ In the event of my death, I request that my agent inform my family or next of kin of my desire to be an organ and tissue donor for **research**. *(Initial if applicable)*

_____ My Initials

RELIGIOUS AND SPIRITUAL REQUESTS

Do you want your Rabbi, Priest, Clergy, Minister, Imam, Monk, or other spiritual advisor contacted if you become sick?

INITIAL ONLY ONE:
_____ Yes _____ No

Name of Rabbi, Priest, Clergy, Minister, Imam, Monk, or other spiritual advisor:
_____

Address:_____

Phone Number: _____

DURATION

Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.

I do not want this durable power of attorney for health care to exist until revoked. I want this durable power of attorney for health care to expire on _____
(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)

REVOCATION

I can revoke this Durable Power of Attorney for Health Care at any time and for any reason either in writing or orally. If I change my agent or alternative agents or make any other changes, I need to complete a new Durable Power of Attorney for Health Care with those changes.

PART III: MAKING THE DOCUMENT LEGAL

I revoke any prior designations, advance directives, or durable power of attorney for health care.

Date and Signature of Principal

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

_____

Signature Date signed:

_____ My Initials

DATE AND SIGNATURES OF TWO QUALIFIED WITNESSES OR ONE NOTARY PUBLIC

Two qualified witnesses or one notary public must sign the durable power of attorney for health care form at the same time the principal signs the document. The witnesses must be adults and must not be any of the following:

(1) a person you designate as your agent or alternate agent,
(2) a health care provider,
(3) an employee of a health care provider,
(4) the operator of a community care facility, or
(5) an employee of an operator of a community care facility.

I declare under the penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, or an employee of an operator of a community care facility.

OPTION ONE:

Signature: _____
Print Name: _____
Residence Address: _____
Date: _____

Signature: _____
Print Name: _____
Residence Address: _____
Date: _____

----------OR----------

OPTION TWO:

Signature of Notary Public: _____
Print Name: _____
Commission Expires: _____
Business Address: _____
Date: _____

_____ My Initials

TWO QUALIFIED WITNESSES OR ONE NOTARY PUBLIC DECLARATION

At least one of the qualified witnesses or the notary public must make this additional declaration:

I further declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

Print Name: _____

Signature: _____

Print Name: _____

PART IV: DISTRIBUTING THE DOCUMENT

You are not required to give anyone your Durable Power of Attorney for Health Care, but if it cannot be found at the time you need it, it cannot help you. For example, you are unable to participate in making health care decisions and your Durable Power of Attorney for Health Care is a safe deposit box, the agent, physician and other health care providers will not have access to it and they will not be able to respect your medical treatment wishes. You may want to give a copy of your Durable Power of Attorney for Health Care to some or all of the persons listed below so that it can be available when you need it.

(Name) (Address) (Phone)

q Health Care Agent

_____

q First Alternative Health Care Agent

_____

q Second Alternative Health Care Agent

_____

q Physician

_____

q Family

_____

q Lawyer

_____

q Others

_____

_____ My Initials

ADDITIONAL SPACE FOR INFORMATION

_____ **My Initials**

INSTRUCTIONS
To Living Will

A living will is a written document which directs your physician to withhold or stop life-sustaining medical procedures if you develop a terminal condition and can't state your wishes at the time a decision about those kinds of procedures must be made.

Rhode Island law suggests a form of living will but does not require its exclusive use. If you decide to sign a living will, you may use the form supplied with these instructions or make your own living will form. If you use this form, please read and follow these instructions carefully.

1. Print your name in the first line of the form.

2. Place a check mark in the third paragraph to indicate whether you want artificially-administered nutrition and hydration (food and water) to be stopped or withheld like any other life-sustaining treatment. Remember, if you do not want artificial nutrition and hydration, your living will must say so.

3. Complete the day, month and year that you sign at the bottom of this form.

4. Sign your name on the signature line (or if you are unable to do so, have someone do it for you) before two (2) witnesses who know you and are at least 18 years old.

5. Print your address on the address line.

6. Have the two (2) witnesses sign their names and print their addresses where indicated below your signature. The witnesses may not be related to you by blood or marriage.

7. Give a signed copy of your living will to your physician for your medical records.

   Remember, you may revoke your living will at any time simply by telling your physician not to follow it.

NOTE: This information is provided to make you generally aware of Rhode Island law about living wills and is not intended as legal advice for your particular situation. For legal advice about living wills or your health care rights, you should consult with an attorney.

STATE OF RHODE ISLAND

CHAPTER 23-4.11
A declaration may, but need not, be in the following form:

RIGHTS OF THE TERMINALLY ILL ACT

DECLARATION

I, _____, being of sound mind willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, so hereby declare:

If I should have an incurable or irreversible condition that will cause my death and if I am unable to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort, or to alleviate pain.

This authorization ☐ includes ☐ does not include

the withholding or withdrawal of artificial feeding. *(check only one box above)*

Signed this _____ day of _____, _____.

_____
Signature of Declarant

_____
Address

The Declarant is personally known to me and voluntarily signed this document in my presence. I am not related to the Declarant by blood or marriage.

_____ _____
Witness Witness

_____ _____
Address Address