INSTRUCTIONS	**KANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS GENERAL STATEMENT OF AUTHORITY GRANTED – PAGE 1 OF 4**
PRINT YOUR NAME	I , ______________________________ , (name)
PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR PROXY	designate and appoint: ______________________________ (name of proxy) ______________________________ (address) ____________________ (home telephone number) ____________________ (work telephone number) or, in the event the person I appoint above is unable, unwilling or unavailable to serve, I appoint:
PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR ALTERNATE PROXY	______________________________ (name of alternate proxy) ______________________________ (address) ____________________ (home telephone number) ____________________ (work telephone number) to be my proxy for health care decisions and pursuant to the language stated below, on my behalf to: (1) Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition, and to make decisions about organ donation, autopsy and disposition of the body; (2) make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge health care personnel, to include physicians, psychiatrists, psychologists, dentists, nurses, therapists or any other person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care, as the proxy shall deem necessary for my physical, mental and emotional well being; and
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(3) request, receive and review any information, verbal or written, regarding my personal affairs or physical or mental health, including medical and hospital records, and to execute any releases of other documents that may be required in order to obtain such information.

ADD PERSONAL INSTRUCTIONS (IF ANY)

In exercising the grant of authority set forth above my proxy for health care decisions shall: (Here may be inserted any special instructions or statement of the principal's desires to be followed by the proxy in exercising the authority granted)

LIMITATIONS OF AUTHORITY

LIST LIMITATIONS ON YOUR PROXY'S POWER TO CONSENT TO MEDICAL TREATMENT (IF ANY)

(1) The powers of the proxy herein shall be limited to the extent set out in writing in this durable power of attorney for health care decisions, and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.

(2) The proxy shall be prohibited from authorizing consent for the following items:

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KANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS GENERAL STATEMENT OF AUTHORITY GRANTED – PAGE 3 OF 4

LIST FURTHER LIMITATIONS TO YOUR PROXY'S POWER (IF ANY)

(3) This durable power of attorney for health care decisions shall be subject to the additional following limitations:

EFFECTIVE TIME

This power of attorney for health care decisions shall become effective upon my disability or incapacity.

REVOCATION

Any durable power of attorney for health care decisions I have previously made is hereby revoked.

PRINT THE DATE AND COUNTY OF EXECUTION

EXECUTION

Executed this ______________, at ______________________, Kansas.
(date) (county)

SIGN THE DOCUMENT

____
(principal)

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KANSAS DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS – PAGE 4 OF 4

WITNESSING PROCEDURE

This document must be: (1) Witnessed by two individuals of lawful age who are not the proxy, not related to the principal by blood, marriage or adoption, not entitled to any portion of the principal's estate and not financially responsible for the principal's health care; OR (2) acknowledged by a notary public.

WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

Witness ____

Address ____

____

Witness ____

Address ____

OR

OR

A NOTARY PUBLIC MUST COMPLETE THIS SECTION OF YOUR DOCUMENT

STATE OF KANSAS)
SS.
COUNTY OF)

This instrument was acknowledged before me on

____
(date)

by ________________________________ .
(name of principal)

____
(signature of notary public)

(Seal, if any)

My appointment expires: ____________________

INSTRUCTIONS

PRINT THE DATE

Declaration made this ____________day of _______________ ____________
(day) (month) (year)

PRINT YOUR NAME

I, ____
(name)

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, and do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

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ORGAN DONATION (OPTIONAL)

ORGAN DONATION (OPTIONAL)
Under Kansas law, you may make a gift of all or part of your body to a bank or storage facility or a hospital, physician or medical or dental school for transplantation, therapy, medical or dental evaluation or research or for the advancement of medical or dental science. You may also authorize your agent to do so or a member of your family may make a gift unless you give them notice orally or in writing that you do not want a gift made.

You may revoke or amend an anatomical gift by: (1) the execution of a signed statement; (2) an oral statement that is made in the presence of two persons, at least one of whom is a disinterested witness, and communicated to your family or attorney or to the donee; (3) a statement during a terminal illness or injury addressed to an attending physician; (4) a signed card or document found on you or in your personal effects; or (5) by destruction, cancellation, or mutilation of the document providing for the anatomical gift and all executed copies thereof.

In the space below you may make a gift yourself or state that you do not want to make a gift. If you do not complete this section, your agent will have the authority to make a gift of all or a part of your body pursuant to law. The donation elections you make below survive your death.

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your agent and your family will have the authority to make a gift of all or part of your body under Kansas law.

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

_____I do not want to make an organ or tissue donation and I do not want my agent or family to do so.
______I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/organization:______________________________________
_____Pursuant to Kansas law, I hereby give, effective on my death:
    ______Any needed organ or parts.
    ______The following part or organs listed below:

For (initial one):
    ______Any legally authorized purpose.
    ______Transplant or therapeutic purposes only.

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ADD ANY PERSONAL INSTRUCTIONS REGARDING ORGAN DONATION HERE

Other directions:

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

SIGN THE DOCUMENT AND PRINT YOUR PLACE OF RESIDENCE

Signed ____

City, County and State of Residence ______________________________

____

WITNESSING PROCEDURE

WITNESSES MUST SIGN BELOW

The declarant has been personally known to me and I believe him or her to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of interstate succession or under any will of declarant or codicil thereto, or directly financially responsible for the declarant's medical care.

WITNESS #1

Witness ____

WITNESS #2

Witness ____

OR

A NOTARY PUBLIC MUST COMPLETE THIS SECTION OF YOUR DOCUMENT

OR

STATE OF KANSAS)
SS.
COUNTY OF)

This instrument was acknowledged before me on ________________________
(date)

by ____________________________________ .
(name of principal)

____
(signature of notary public)

(Seal, if any)

My appointment expires: ______________________

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You Have Filled Out Your Advance Directive, Now What?

1. Your Kansas Advance Directive for Healthcare decisions is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your proxy and alternate proxy, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your proxy(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

5. Remember, you can always revoke your document.

6. Be aware that your document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Hutchinson Regional Medical Center does not distribute these forms.**