

INSTRUCTIONS

PRINT YOUR NAME  
AND COUNTY

**DURABLE HEALTH CARE  
POWER OF ATTORNEY**

I, Thaddeus M Poe, of Delaware County,  
Pennsylvania, appoint the person named below to be my health care  
agent to make health and personal care decisions for me.

Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my health care agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the regulations promulgated there under and any other State or local laws and rules. Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by 45 C.F.R. Pt. 164.

The remainder of this document will take effect when and only when I lack the ability to understand, make or communicate a choice regarding a health or personal care decision as verified by my attending physician. My health care agent may not delegate the authority to make decisions.

MY HEALTH CARE AGENT HAS ALL OF THE FOLLOWING POWERS SUBJECT TO THE HEALTH CARE TREATMENT INSTRUCTIONS THAT FOLLOW IN NUMBER 3 ON PAGE 13 (CROSS OUT ANY POWERS YOU DO NOT WANT TO GIVE YOUR health care AGENT):

1. To authorize, withhold or withdraw medical care and surgical procedures.
2. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.
3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.

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4. To hire and fire medical, social service and other support personnel responsible for my care.
5. To take any legal action necessary to do what I have directed.
6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.

**APPOINTMENT OF HEALTH CARE AGENT**

I appoint the following health care agent:

Health care agent:

Linda Pope wife (Name and relationship)

Address: 32 Dartmouth Circle Swarthmore  
PA 19081

Telephone Number: Home 310 270 3187 Work \_\_\_\_\_

E-mail: LBpope@aol.com

IF YOU DO NOT NAME A HEALTH CARE AGENT, HEALTH CARE PROVIDERS WILL ASK YOUR FAMILY OR AN ADULT WHO KNOWS YOUR PREFERENCES AND VALUES FOR HELP IN DETERMINING YOUR WISHES FOR TREATMENT. NOTE THAT YOU MAY NOT APPOINT YOUR DOCTOR OR OTHER HEALTH CARE PROVIDER AS YOUR HEALTH CARE AGENT UNLESS RELATED TO YOU BY BLOOD, MARRIAGE OR ADOPTION.

If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named. (It is helpful, but not required, to name alternative health care agents.)

PRINT THE NAME,  
RELATIONSHIP AND  
ADDRESS OF YOUR  
AGENT

PRINT PHONE  
NUMBER AND EMAIL  
ADDRESS OF YOUR  
AGENT

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PRINT THE NAME,  
ADDRESS, PHONE  
NUMBER AND EMAIL  
ADDRESS OF YOUR  
FIRST AND SECOND  
ALTERNATE  
HEALTHCARE  
AGENTS

First Alternative Health Care Agent:

Reina Pope mother

(Name and relationship)

Address: 545 E Wells Street #802

Milwaukee WI 53202

Telephone Number: Home 414 704 7069 Work \_\_\_\_\_

E-mail: nugatory2003@yahoo.com

Second Alternative Health Care Agent:

Lawrence Pope father

(Name and relationship)

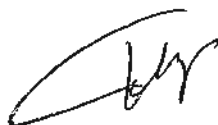
Address: 545 E Wells Street #802

Milwaukee WI 53202

Telephone Number: Home 414 727 8516 Work 312 752 0725

E-mail: lawrenceS2005@yahoo.com

While an available agent has authority before any lower-ranked agent, all agents and alternative agents should consult and confer. The highest-ranked agent still has sole decision-making authority.



OPTIONAL  
GUIDANCE FOR  
YOUR HEALTH CARE  
AGENT

*GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL)*

GOALS

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your personal priorities such as comfort, care, preservation of mental function, etc.):

Maintain so long as I can interact with my environment and recognized loved ones. Maintain until family can visit and say goodbye. Otherwise comfort care only.

SEVERE BRAIN DAMAGE OR BRAIN DISEASE

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome. I therefore request that my health care agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below.

Initials   *JH*   I agree

Initials \_\_\_\_\_ I disagree

Continue aggressive interventions until near certitude of diagnosis and prognosis. Do not implement withhold, withdraw instructions until, and after sufficient time, to make diagnosis, prognosis with informed confidence.

PRINT ANY GOALS  
FOR YOUR HEALTH  
CARE AGENT

SELECT ONE AND  
INITIAL

LIVING WILL

**HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF  
END-STAGE MEDICAL CONDITION  
OR  
PERMANENT UNCONSCIOUSNESS  
(LIVING WILL)**

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make or communicate my treatment decisions:

IF I HAVE AN END-STAGE MEDICAL CONDITION (WHICH WILL RESULT IN MY DEATH, DESPITE THE INTRODUCTION OR CONTINUATION OF MEDICAL TREATMENT) OR AM PERMANENTLY UNCONSCIOUS SUCH AS AN IRREVERSIBLE COMA OR AN IRREVERSIBLE VEGETATIVE STATE AND THERE IS NO REALISTIC HOPE OF SIGNIFICANT RECOVERY, ALL OF THE FOLLOWING APPLY (CROSS OUT ANY TREATMENT INSTRUCTIONS WITH WHICH YOU DO NOT AGREE):

CROSS OUT ANY TREATMENT INSTRUCTIONS WITH WHICH YOU DISAGREE

1. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming.

2. I direct that all life prolonging procedures be withheld or withdrawn.

3. I specifically do not want any of the following as life prolonging procedures: (If you wish to receive any of these treatments, write "I do want" after the treatment)

WRITE "I DO WANT" IF YOU WISH TO RECEIVE THESE TREATMENTS

heart-lung resuscitation (CPR) See \*

mechanical ventilator (breathing machine) See \*

dialysis (kidney machine) See \*

surgery See \*

chemotherapy See \*

radiation treatment See \*

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I want these only if either (1) I can interact with my environment meaningfully, or (2) there is a good (more than 5%) chance I might regain that ability.

Antibiotics see \*

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries, or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery.

(Initial only one statement.)  
TUBE FEEDINGS

I want tube feedings to be given

OR

NO TUBE FEEDINGS

I do not want tube feedings to be given. see \*

*HEALTH CARE AGENT'S USE OF INSTRUCTIONS*

(INITIAL ONE OPTION ONLY)

My health care agent must follow these instructions. JMP

OR

These instructions are only guidance. My health care agent shall have final say and may override any of my instructions. (Indicate any exceptions) \_\_\_\_\_

If I did not appoint a health care agent, these instructions shall be followed.

*LEGAL PROTECTION*

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions.

SELECT ONE AND INITIAL

SELECT ONE AND INITIAL



ORGAN DONATION (Optional)

Under Pennsylvania 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. In the space below you may make a gift yourself or state that you do not want to make a gift. An individual may revoke or amend an anatomical gift by: (1) destruction, cancellation or mutilation of this document and all executed copies thereof; (2) execution of a signed statement; (3) an oral statement made in the presence of two persons; (4) a statement during a terminal illness or injury addressed to an attending physician, or (5) a signed card or document found on his person or in his effects.

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 Pennsylvania law.

SELECT ONE AND INITIAL

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: \_\_\_\_\_

SELECT ONE AND INITIAL

Pursuant Pennsylvania law, I hereby give, effective on my death (initial one)

Any needed organ or parts.

SELECT ONE AND INITIAL

The following part or organs listed below:

For (initial one):

Any legally authorized purpose.

Transplant or therapeutic purposes only.

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**Note:** A gift of the whole body shall be invalid unless made in writing at least fifteen days prior to the date of the death, or consent is obtained from the legal next of kin.

These wishes are also reflected on my PA drivers license.

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SIGNATURE

Having carefully read this document, I have signed it this 23 day of July, 2009, revoking all previous health care powers of attorney and health care treatment instructions.

[Handwritten Signature]

(SIGN FULL NAME HERE FOR HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE TREATMENT INSTRUCTIONS)

WITNESS: Linda Pope 7-23-09

WITNESS: T. C. Basse 7-23-09

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)

NOTARIZATION (OPTIONAL)

(Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other states.)

On this \_\_\_ day of \_\_\_\_\_, 20\_\_\_, before me personally appeared the aforesaid declarant and principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of \_\_\_\_\_, State of \_\_\_\_\_ the day and year first above written.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
My commission expires

PRINT THE DATE AND SIGN

WITNESS PROCEDURE

YOUR TWO WITNESSES MUST SIGN HERE

OPTIONAL NOTARIZATION

HAVE NOTARY FILL OUT THIS SECTION

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